

10 No. 97-1489-CFX Title: Your Home Visiting Nurse Services, Inc., Petitioner  
v.  
Donna E. Shalala, Secretary of Health and Human  
Services

Docketed:

March 11, 1998

Court: United States Court of Appeals for  
the Sixth Circuit

Entry Date

Proceedings and Orders

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Mar 11 1998	Petition for writ of certiorari filed. (Response due May 11, 1998)
Apr 1 1998	Order extending time to file response to petition until May 11, 1998.
May 11 1998	Brief of respondent Donna Shalala, Secretary of Health and Human Services filed.
May 21 1998	Reply brief of petitioner Your Home Visiting Nurse Services, Inc. filed.
May 26 1998	DISTRIBUTED. June 11, 1998
Jun 15 1998	Petition GRANTED. limited to Questions 1 and 2 presented by the petition. SET FOR ARGUMENT December 2, 1998. *****
Jul 20 1998	Record filed.
Jul 22 1998	Brief of petitioner Your Home Visiting Nurse Service filed.
Jul 22 1998	Joint appendix filed.
Jul 29 1998	Brief amici curiae of American Hospital Association, et al. filed.
Aug 3 1998	Record filed.
Aug 13 1998	Order extending time to file brief of respondent on the merits until September 18, 1998.
Sep 18 1998	Brief of respondent Donna Shalala, Secretary of Health and Human Services filed.
Oct 20 1998	Reply brief of petitioner Your Home Visiting Nurse Services, Inc. filed.
Oct 22 1998	Motion of Oklahoma Hospital Association, et al. for leave to file a brief as amici curiae out-of-time filed.
Nov 2 1998	Motion of Oklahoma Hospital Association, et al. for leave to file a brief as amici curiae out-of-time DENIED.
Nov 6 1998	CIRCULATED.
Nov 17 1998	Portions of Provider Reimbursement Manual lodged with Court.
Dec 2 1998	ARGUED.

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Supreme Court, U.S.  
FILED

971489 MAR 11 1998

No. \_\_\_\_\_ OFFICE OF THE CLERK

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In The  
**Supreme Court of the United States**  
October Term, 1997

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YOUR HOME VISITING NURSE SERVICES, INC.,  
*Petitioner,*

v.

SECRETARY OF HHS,  
*Respondent.*

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On Petition For Writ Of Certiorari  
To The United States Court Of Appeals  
For The Sixth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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**QUESTIONS PRESENTED FOR REVIEW**

- I. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under:
  - 42 U.S.C. § 1395oo
  - 28 U.S.C. § 1331
  - 28 U.S.C. § 1361
  - 5 U.S.C. § 706
- II. Is regulation 42 C.F.R. § 405.1885(c) based on a permissible construction of the Medicare statute?
- III. Does the Secretary's interpretation of the Medicare statute and the regulation which prohibits review constitute a deprivation of due process under the United States Constitution, Amendment V?
- IV. In the event that petitioner prevails, is there justification for an award of attorneys fees under the Equal Access to Justice Act 5 U.S.C. § 504 and 28 U.S.C. § 2412, because the Government's action was not substantially justified?

## PARTIES TO THE PROCEEDINGS

The petitioner, plaintiff-appellant in the proceeding below, is Your Home Visiting Nurse Services, Inc. and its home health care agency providers licensed as numbers 44-7100, 44-7300, 44-7234, and 44-7304 (Tennessee corporations). There is no parent or non-wholly owned subsidiary company to be listed as required by United States Supreme Court Rule 29.6.

Respondent is the Secretary of Health and Human Services, represented by Counsel for the Department of Health and Human Services.

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## PETITION FOR WRIT OF CERTIORARI

Your Home Visiting Nurse Services, Inc. respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.



## OPINIONS BELOW

The opinion of the court of appeals (App., *infra*,) is reported at 1997 U.S. App. LEXIS 35873. The opinion of the district court (App., *infra*,) is unreported.



## STATEMENT OF JURISDICTION

The court of appeals for the Sixth Circuit entered its judgment on December 22, 1997 (App., *infra*,). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS AND  
OTHER AUTHORITIES INVOLVED

The statutory provisions and other authorities involved include: 5 U.S.C. § 504; 5 U.S.C. § 706; 28 U.S.C. § 1254(1); 28 U.S.C. § 1331; 28 U.S.C. § 1361; 28 U.S.C. § 2412; 42 U.S.C. § 405(h); 42 U.S.C. § 1395x(v)(1)(A)(ii); 42 U.S.C. § 1395oo; U.S. Const. amend. V; 42 C.F.R. § 405.1885; 42 C.F.R. § 421.5(b).



### STATEMENT OF THE CASE

The petitioner provides home health services to Medicare beneficiaries and receives reimbursement from Medicare. The Medicare Program is administered by the United States Department of Health and Human Services. Annual cost reports are submitted to fiscal intermediaries such as Blue Cross and Blue Shield of South Carolina, an agent of the Secretary of Health and Human Services.

The petitioner discovered new and material evidence that suggested the 1989 cost reports should be reopened. Within the appropriate time period (three years from the date of the Notice of Program Reimbursement letters which had closed the 1989 cost reports) the petitioner made requests for reopening. Blue Cross refused to reopen the cost reports. Petitioner appealed the denial to reopen the cost reports to the Provider Reimbursement Review Board. The Board would not accept jurisdiction of the case. Petitioner appealed the Board's decision to the district court, where the case was dismissed and the Board's decision was upheld. The district court also determined that it did not have the authority to review the fiscal intermediary's refusal to reopen the cost reports by resorting to alternative theories of jurisdiction. The Sixth Circuit Court of Appeals affirmed the district court decision.

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### REASONS FOR GRANTING THE WRIT

#### I. The Sixth Circuit decision is in conflict with the decision of other United States Court of Appeals.

The petitioner respectfully requests Supreme Court review of the latest decision in a line of conflicting cases regarding the right to judicial review. During the years 1984 through 1997, six separate decisions were rendered on this question of law. In *Your Home Visiting Nurse Services, Inc. v. Shalala*, No. 96-5525 (6th Cir. Dec. 22, 1997), the Sixth Circuit Court of Appeals has effectively joined with the Second Circuit and the District of Columbia Circuit to deny judicial review of a refusal to reopen a Medicare cost report.

In this case, an employee of an insurance company made a decision which thus far has been insulated from judicial review. The insurance company who employed this individual contracts with the Health Care Financing Administration to act as the fiscal intermediary and agent of the Secretary of Health and Human Services in administering Medicare reimbursement. The intermediary (through the insurance company employee) refused to grant petitioner's request to reopen its Medicare cost reports. Petitioner asserts that the refusal to reopen the cost report was arbitrary, capricious, and otherwise inappropriate under the law.

The Sixth Circuit Court of Appeals' decision perpetuates the dispute among the circuit courts on this issue. Six federal court cases referenced below examined some of the same key provisions of the Medicare statute:

- 42 U.S.C. § 1395oo(a) (West Supp. 1996) – appeal process for providers dissatisfied with a final determination
- 42 U.S.C. § 1395x(v)(1)(A)(ii) (West Supp. 1997) – reasonable cost, regulations, retroactive corrective adjustments
- 42 U.S.C. § 405(h) (West Supp. 1997) – finality of Secretary's decision

Nevertheless, the courts are not in agreement.

The Ninth Circuit Court of Appeals addressed this question in 1988, holding that review is available under 42 U.S.C. § 1395oo(a) and that the Provider Reimbursement Review Board has jurisdiction to review the fiscal intermediary's decision not to reopen a cost report. *Oregon v. Bowen*, 854 F.2d 346 (9th Cir. 1988). As a result of that decision, providers located within the Ninth Circuit have a right to obtain review of a refusal to reopen a cost report by appeal to the Provider Reimbursement Review Board. (Providers may then obtain judicial review of the Secretary's final determination after completion of the administrative review process outlined in the statute.) The Provider Reimbursement Review Board manual contains a provision which allows review of this issue if, and only if, the provider is located in the Ninth Circuit:

Refusal to Reopen. – A refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 C.F.R. § 1885(c), except for providers which are located within the jurisdiction of the U.S. Ninth Circuit Court of Appeals, where such a refusal to reopen is appealable. In such Ninth Circuit cases, the issue to be heard by the Board

is whether the intermediary abused its discretion in refusing to reopen such determination or decision.

*Prov. Reimb. Man.*, Part I, § 2926.6.

In *Oregon*, 854 F.2d 346, the court recognized the plain meaning of 42 U.S.C. § 1395oo(a) entitled the provider to review of a refusal to reopen the cost report. Petitioner urges this Court to accept this petition to resolve the dispute as to the plain meaning of the statute:

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –

(1) such provider

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . . as to the amount of total program reimbursement due the provider for the items and services furnished . . .

. . .

. . .

. . .

(2) the amount in controversy is \$10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i).

42 U.S.C. § 1395oo(a).

An intermediary's refusal to reopen a cost report is a final determination. It is not a temporary decision scheduled for a later review, but is, admittedly, final. "Although the NPR is often the final determination in question, the fiscal intermediary's refusal to reopen also qualifies as a final determination, a fact the Secretary concedes in his briefs." *Oregon*, 854 F.2d at 349.

While the Eighth Circuit Court of Appeals has not yet ruled on the precise question of judicial review of an intermediary's refusal to reopen a Medicare cost report, in 1996 it did remand a case back to the district court for additional findings of fact regarding circumstances required to validate the intermediary's decision to reopen a cost report. *Hennepin County Medical Center v. Shalala*, 81 F.3d 743 (8th Cir. 1996). The court questioned the existence of *new and material information* sufficient to justify the intermediary's decision to reopen the cost reports. *Id.* These questions were to be answered by the district court through further proceedings. *Id.* The Eighth Circuit has obviously decided that a district court has the right to review the reopening process. The *Hennepin* court made reference to *Oregon*, 854 F.2d 346, the Ninth Circuit case which allows review of a refusal to reopen a cost report.

In 1984, four years before the Ninth Circuit decision on the matter, the District of Columbia Circuit Court of Appeals ruled on the issue of judicial review for a refusal to reopen a cost report. In *St. Mary of Nazareth Hospital Center v. Schweiker*, 741 F.2d 1447 (D.C. Cir. 1984), the court held that 42 C.F.R. § 405.1885(c) makes denials of reopenings *unreviewable*. Nevertheless, in 1991, a district court within the District of Columbia Circuit acknowledged jurisdiction to review an intermediary's refusal to reopen

a cost report by virtue of the federal question statute, 28 U.S.C. § 1331, and the mandamus statute, 28 U.S.C. § 1361. *Memorial Hospital v. Sullivan*, 779 F. Supp. 1406 (D.D.C. 1991).

The district court in *Memorial Hospital* found alternative sources to allow review of an intermediary's refusal to reopen cost reports. *Id.* The district court felt it was inappropriate for the Secretary to direct providers not to appeal to the Provider Reimbursement Review Board, but instead to file for reopening of their cost reports to include self-disallowed data, only to have the request for reopening denied. *Id.*

[T]he Secretary cannot relegate providers to a dead-end procedure under the Medicare statute, and then argue that the provider loses because the Medicare statute is the exclusive means of redress. When such bureaucratic red tape strangles a provider's right to judicial review, the Court may invoke its federal question jurisdiction and mandamus power.

*Id.* at 1412.

Based upon the record presented in that case, the court found that the intermediary acted arbitrarily, capriciously, and abused its discretion in denying the plaintiff's request to reopen the cost reports citing the HHS regulation and Provider Reimbursement manual sections which require a reopening in the event that "new and material evidence has been submitted." *Id.* at 1412-13. Because there was new evidence and an inconsistency of law, there was a basis for reopening. This fact is important since even the District of Columbia Circuit recognized that reopening is permitted to hear new evidence.

*St. Mary of Nazareth*, 741 F.2d at 1449 (citing *Community Hospital v. Schweiker*, 686 F.2d 989, 996 (D.D.C. 1982) (emphasis in original)). The same reasoning was set forth by this Court in the case of *Interstate Commerce Commission v. Brotherhood of Locomotive Engineers*, 482 U.S. 270 (1987). "If review of denial to reopen for new evidence or change in circumstance is unavailable, the petitioner will have been deprived of all opportunity for judicial consideration – even on a 'clearest abuse of discretion' basis – of facts which, through no fault of his own, the original proceedings did not contain." *Id.* at 270.

The Second Circuit Court of Appeals did not accept the *Oregon* explanation of the plain meaning of the statute. *Good Samaritan Hospital Regional Medical Center v. Shalala*, 85 F.3d 1057 (2nd Cir. 1996). Instead, the Second Circuit endorsed the game of statutory construction played by a district court in the Southern District of New York:

While . . . a decision not to reopen is in some sense "final," it does not in and of itself establish an "amount of total reimbursement." Instead it is a final determination that there are not grounds on which to reconsider a previous final determination as to the amount of total program reimbursement.

*Good Samaritan*, 85 F.3d at 1061 (citing *Good Samaritan Hospital*, 894 F.Supp. at 690 (complete citation omitted in original) (citing *Staten Island Hospital v. Sullivan*, No. 91-Civ-733, 1992 WL 675952, at 5 n. 6 (D.D.C. Mar. 31, 1992))).

The *Good Samaritan* court position is not, in petitioner's view, a reasonable reading of the statute. Moreover, it neglects to address the heart of the problem. If the

refusal to reopen is not a final determination for purposes of appeal, but is a final determination that there are not grounds on which to reconsider a previous final determination, what recourse is available to the provider with valid grounds for the reopening, whose reopening request is denied? The rationale put forth in *Good Samaritan* leaves a provider wrongfully denied a reopening with no remedy or redress. These cases present two questions for this Court to resolve:

1. Which construction of 42 U.S.C. § 1395oo(a) is correct?
2. Is there an alternative basis for jurisdiction to review a refusal to reopen a Medicare cost report?

## II. There is a presumption of judicial review.

This Court has not yet reviewed the question of a Medicare provider's right to judicial review of the refusal to reopen a cost report. However, two conflicting decisions from this Court were repeatedly cited for opposing propositions by the parties herein. In 1977, this Court held there is no review for a refusal to reopen a previously adjudicated claim for social security benefits under section 10 of the Administrative Procedure Act. *Califano v. Sanders*, 430 U.S. 99 (1977). Ten years later, this Court ruled on the reopening question again, but stated that: "only when a petition to reopen and reconsider an agency order alleges new evidence or changed circumstances is the agency's refusal to reopen subject to judicial review, and then, only as to whether such refusal was arbitrary,

capricious, or an abuse of discretion." *Interstate Commerce Commission*, 482 U.S. at 271.

This Court has long recognized the strong presumption of judicial review dating back to the year 1803 when Chief Justice Marshall insisted that "the very essence of civil liberty certainly consists in the right of every individual to claim protection of the laws." *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 670 (1986) (citing *Marbury v. Madison*, 1 Cranch 137, 163, 2 L. Ed. 60 (1803)). In 1835, the Chief Justice again noted the traditional observance of this right which has laid the foundation for our modern presumption of judicial review:

"It would excite some surprise if, in a government of laws and of principle, furnished with a department, whose appropriate duty it is to decide questions of right, not only between individuals, but between the government and individuals; *a ministerial officer might, at his discretion, issue this powerful process . . . leaving the debtor no remedy, no appeal to the laws of his country*, if he should believe the claim to be unjust. But this anomaly does not exist; this imputation cannot be cast on the legislature of the United States."

*Id.* (citing *United States v. Nourse*, 9 Pet. 8, 28-29, 9 L. Ed. 31 (1835) (emphasis added)). The Court in *Michigan Academy* goes on to point out that:

Committees of both Houses of Congress have endorsed this view. In undertaking the comprehensive rethinking of the place of administrative agencies in a regime of separate and divided powers that culminated in the passage of the Administrative Procedure Act (APA) . . . the

Senate Committee on the Judiciary remarked: "*Very rarely do statutes withhold judicial review*. It has never been the policy of Congress to prevent the administration of its own statutes from being judicially confined to the scope of authority granted or to the objectives specified. Its policy could not be otherwise, for in such a case statutes would in effect be blank checks drawn to the credit of some administrative officer or board."

*Id.* at 670-71 (citing S. Rep. No. 79-752, at 26 (1945) (emphasis added)). More evidence was offered by the court in *Michigan Academy*, *id.* at 671, through review of the H.R. Rep. No. 79-1980, at 41 (1946) where the committee on the Judiciary of the House of Representatives agreed that Congress intends that there be judicial review, and emphasized the clarity and precision with which a contrary intent must be expressed.

In the petitioner's case, the statute at issue expressly provides for judicial review of final determinations, though it does not expressly define a refusal to reopen a cost report as being a final determination which can be appealed. 42 U.S.C. § 1395oo(a). The statute sets out the method for obtaining judicial review when a provider is dissatisfied with a final determination related to Medicare reimbursement. *Id.* While the statute does not preclude judicial review, the Secretary of Health and Human Services cuts off any review process through a regulation which is interpreted to preclude judicial review. The regulation at issue is 42 C.F.R. § 405.1885(c) (1997) which states that "jurisdiction for reopening a determination or decision rests exclusively with the administrative body that rendered the last determination or decision."

Although the language of the regulation does not expressly prohibit review of the determination, the Secretary's interpretation of the regulation does. The manual which the Secretary of HHS provides to her agents as direction for the implementation of the law clearly shows the Secretary intends to deny review:

Notice of Refusal to Reopen or Correct. - A provider has no right to a hearing on a finding by an intermediary or a hearing officer that a reopening or correction of a determination or decision is not warranted. Accordingly a hearing paragraph should not be included in any letter or notice setting forth such a finding. The notice will, however, explain the basis for refusing to reopen or correct the determination or decision and will be issued by the intermediary, hearing officer, PRRB or the Secretary having responsibility for the reopening according to 2931.

*Prov. Reimb. Man., Part I § 2932.1.*

As a result of these instructions, even in the most egregious circumstances, an intermediary's refusal to reopen a cost report will not be reviewed in any manner, and certainly not by the Provider Reimbursement Review Board, *unless the provider is fortunate enough to be located within the Ninth Circuit Court of Appeals jurisdiction.* Providers within the Ninth Circuit must be aware of their right to request review based upon the Ninth Circuit Court of Appeals decision because the Secretary of HHS does not inform them of their right to review. Regardless of the magnitude of injustice committed by an intermediary's refusal to allow a reopening, there is no recourse for

a provider *unless they are located within the Ninth Circuit Court of Appeals district and know the Ninth Circuit law.*

This Court reviewed the Medicare statute in 1986 and ruled that judicial review was warranted in *Michigan Academy*, 476 U.S. 667. Many of the same sections of the Medicare statute which led this Court to grant judicial review in that case have been addressed by the lower court decisions which led to this petition for certiorari. The continuing relevance of the *Michigan Academy* ruling was questioned by the Sixth Circuit Court of Appeals. (App. 1) The competing constructions of the statutes and the Supreme Court decisions should be addressed by this Court. There is an obvious need for this Court to come to a final conclusion on this question and end the disparity between the federal courts which exists today. The map at page 54 of the Appendix demonstrates the impact of this dilemma upon the nation.

The petitioner in the present case offered new and material evidence in support of its request to reopen the 1989 Medicare cost reports. Therefore, petitioner demonstrated circumstances to justify reopening. Unfortunately, this evidence was not examined by the Provider Reimbursement Review Board, the U.S. District Court for the Eastern District of Tennessee, or the Sixth Circuit Court of Appeals due to their refusal to accept jurisdiction of this case to either hear the merits of the petitioner's argument or to remand the case to the appropriate forum to hear the merits of the petitioner's allegations that the intermediary acted arbitrarily and capriciously in its refusal to reopen the cost reports. A reviewing court should set aside agency action that is arbitrary, capricious, and an abuse of discretion. 5 U.S.C. § 706 (West 1996).

The petitioner asserts that the evidence offered was sufficient to justify the re-opening of the cost report with a suitable retroactive adjustment. The Medicare statute requires the Secretary of HHS to promulgate regulations for the implementation of such corrective adjustments. 42 U.S.C. § 1395x(v)(1)(A)(ii). The court in *Oregon*, 854 F.2d at 349 recognized this section of the statute as authority for the reopening regulation: "[n]othing in the plain language of this mandate indicates unreviewability." It is the Secretary's regulation that prohibits review of the intermediary's failure to make an appropriate retroactive corrective adjustment. The standard for assessing the validity of federal regulations appears in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 476 U.S. 837, 842-843 (1984):

When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency must give effect to the unambiguously expressed intent of Congress. If, however, the court determines congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Some regulations are considered unreasonable and therefore fail the second prong of the standard as stated in *Chevron*. The petitioner urges this Court to accept this case in order to examine the Secretary's regulation at 42 C.F.R. § 405.1885(c) for the purpose of determining whether the regulation is a permissible construction of the relevant portions of the Medicare statute.

By accepting this case, this Court will have the opportunity to resolve the statutory construction questions and also address the continuing viability of the Court's decision in *Michigan Academy*, 476 U.S. 667, a case which petitioner asserts is controlling law for this controversy.

In *Michigan Academy*, physicians challenged the validity of a federal regulation which authorized payment of benefits under Part B of the Medicare program in different amounts for similar services. *Id.* Obviously, the physicians who were receiving less reimbursement for rendering similar services did not find the regulation acceptable. The district court held that this regulation, to the extent that it authorized different reimbursement rates for certain physicians, contravened the Medicare statute. The Sixth Circuit expressed the view that:

- (1) the regulation was invalid due to its failure to recognize a statutory mandate that similar physician's services be considered identically, and
- (2) judicial review was not precluded whether by 42 U.S.C. § 405(h) as incorporated into the Medicare program under 42 U.S.C. § 1395ff.

*Id.* at 667. Before *Michigan Academy* was heard at the Supreme Court level, the Sixth Circuit had ruled favorably with regard to the question of the availability of

judicial review and had also reaffirmed its conclusion, after further proceedings, reiterating for a second time that *the validity of the regulation was subject to judicial review*. On Certiorari, this Court affirmed the Sixth Circuit's decision, without deciding the merits as to the validity of the regulation, holding that *judicial review of the validity of a regulation is not precluded by Section 1395ff or Section 405(h). Id.*

There are some striking similarities between the complaint of the physicians in *Michigan Academy* and the petitioner's complaint herein. Both addressed the unfairness of being paid different amounts for the same services. In *Michigan Academy*, 476 U.S. 667, doctors were being paid different amounts. In this case, a nurse and her husband, owners of a Medicare home health agency provider, were being paid less than other owners of home health agencies within the same geographical region. Petitioner is the Medicare Provider that was owned and operated by the nurse and her husband. Owners of providers are entitled to a reasonable amount of compensation for their salary. Each year the fiscal intermediary reviews costs of the provider, including owners' compensation. A dispute arose in the 1980s concerning the appropriate amount of owners' compensation which Medicare would consider allowable reasonable cost. Like the physicians in *Michigan Academy*, the petitioner felt it was unfair to receive less compensation for its owners' salary than the intermediary allowed for their competitors. In *Michigan Academy*, the regulation itself allowed different payment for the same services. *Id.* In the petitioner's case, there is an employee of the intermediary (an insurance company) which allows different payment to be made for

the same services. This was accomplished in part by an intermediary's use of a secret salary survey. Unbeknownst to the petitioner, an intermediary had developed a salary survey for use in determining the amount of salary it would consider allowable for a home health agency owner. The intermediary did not tell the petitioner about this salary survey. Once this salary survey was discovered and the petitioner realized its owners had not been paid as much as competitors were paid for the same type of position, petitioner requested reopening of the 1989 cost reports. The nurse and her husband realized they had not received a fair payment in comparison with their peers. This is a violation of the Medicare statute and Medicare regulations, just like the situation in *Michigan Academy* was a violation of the Medicare statute. "The Sixth Circuit Court of Appeals affirmed and expressed the view that (1) the regulation was invalid due to its failure to recognize a statutory mandate that similar physician's services be considered identically." *Michigan Academy*, 476 U.S. at 667.

Although a specific regulation did not prescribe the inappropriate payment in the petitioner's case, the resulting injustice is the same. While different regulations are in controversy, the basic theme and subject matter in the two cases are quite similar. The regulation at issue in petitioner's case is 42 C.F.R. § 405.1885(c). This regulation does not allow for a review of the intermediary's refusal to reopen the cost report to correct this error concerning the owners' compensation. This Court will surely agree that if it was unfair for physicians who rendered similar services to be paid different amounts then it is also unfair

for owners of a provider to be paid less than their competitors. Without a review of the intermediary's refusal to reopen the cost reports, there is no remedy for this situation.

In *Michigan Academy*, 476 U.S. 667, the physicians complained about the regulation. Not only was the validity of the regulation at issue, but more important for the purposes of consideration of this Writ, *jurisdiction to review the complaint about the regulation* was at issue. *Id.* This Court carefully reviewed the Medicare statute to address questions raised by Section 405(h) concerning jurisdiction. *Id.* (Generally, Section 405(h) is perceived as a bar to federal court jurisdiction when litigants want to shortcut the administrative appeal process by immediate resort to the judiciary.) On appeal to this Court, the Secretary of HHS did not seek review of the Sixth Circuit court's decision in *Michigan Academy* as to the merits of the regulation invalidated. *Id.* Instead, the Secretary renewed the contention that Congress had forbidden judicial review of all questions affecting the amount of benefits payable under Part B of the Medicare program. *Id.* On certiorari, this Court reviewed the appeal process available to individuals who felt they had received less than the appropriate amount of Part B benefits. *Id.* (At that point in time, a more limited review process was available for Part B amount determinations.) The Secretary took the position that Congress had deliberately intended to foreclose further review of part B claims, and urged this Court to accept this position and thus deny the litigants review of the regulation at issue. *Id.* This Court held that the plaintiff's in *Michigan Academy* had mounted

a challenge to the Secretary's regulation, an action which was not foreclosed by Section 1395ff.

The reticulated statutory scheme, which carefully details the forum and limits of review of "any determination . . . of . . . the amount of benefits under part A," and of the "amount of . . . payment" of benefits under Part B, simply does not speak to challenges mounted against the method by which such amounts are to be determined rather than the determinations themselves. As the Secretary has made clear, "the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program" is not considered in a "fair hearing" held by a carrier to resolve a grievance related to a determination of the amount of a part B award. As a result, an attack on the validity of a regulation is not the kind of administrative action that we described in *Erika* as an "amount determination" which decides "the amount of the Medicare payment to be made on a particular claim" and with respect to which the Act impliedly denied judicial review.

*Michigan Academy*, 476 U.S. at 675-76 (citing *Erika* 456 U.S. at 208 (complete citation omitted from original)).

The point was made still clearer by the Court: "[i]n light of Congress' express provision for carrier review of millions of what it characterized as "trivial" claims, it is *implausible* to think it intended there be no forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary." *Id.* at 678 (emphasis added).

The Secretary of HHS had argued that the third sentence of Section 405(h) precludes resort to federal question jurisdiction. This Court rejected that argument and labeled it as an extreme position which "we would be most reluctant to adopt without a showing of 'clear and convincing evidence.'" *Id.* at 681.

The Secretary raised the same arguments in the petitioner's case that were unsuccessful in *Michigan Academy*. By doing so, the Secretary continued to block any and all review of the intermediary's refusal to reopen the petitioner's cost reports.

The Sixth Circuit erred when it failed to consider *Michigan Academy* as controlling in petitioner's case. The Sixth Circuit discounted petitioner's reliance upon *Michigan Academy* by shifting the focus to the inconsequential fact that the case concerned Part B benefits. On this basis, the Sixth Circuit found: "[j]urisdictional questions arising under Part B claims are now treated in this circuit identically to such questions arising under Part A, so *Michigan Academy's* amount/methodology distinction no longer has force." *Your Home*, No. 96-5525, 11 n.3, App. 1. It is the petitioner's position that the significance of the ruling in *Michigan Academy* is not acknowledged by the Sixth Circuit. It is a viable decision which still retains its precedential value in the eyes of this Court. In 1991, this Court cited *Michigan Academy* as controlling law when it held that District Court had federal question jurisdiction to hear respondents' constitutional and statutory challenges to the Immigration and Naturalization Service procedures thereby recognizing the continuing force of the decision. *McNary v. Haitian Refugee Center, Inc.*, 498 U.S. 479, 497 (1991).

Counsel for the petitioner asserts the Sixth Circuit failed to appreciate the important principles espoused in the *Michigan Academy* decision. This Court's ruling in *Michigan Academy*, 476 U.S. 667, did not focus upon the different appeal procedures allowed for Part B versus Part A benefits, but rather, concerned itself with the situation in which the problem presented is not even about the amount of the benefit determination. This Court clearly stated the need for judicial review of complaints about regulations, statutes, and constitutional challenges. *Id.* This is the very essence of the subject matter of petitioner's case. Therefore, the petitioner's case is controlled by the holding of the *Michigan Academy* decision and yet, the Sixth Circuit ignored the decision as precedent.' The Sixth Circuit decision now calls into question the continuing validity of that decision. It is crucial for this Court to accept this petition in order to confirm the continuing precedential effect of *Michigan Academy*, a case that is extremely important to all Medicare providers who must voice a complaint about the Secretary's regulations and her interpretations of the Medicare statute. The Sixth Circuit decision deprives petitioner of the right to due process, as guaranteed by the Fifth Amendment to the Constitution of the United States and sets the stage for all Medicare providers within the Sixth Circuit to have their due process rights violated as well.

Disregarding the precedential value of *Michigan Academy* was not the only serious error made by the Sixth Circuit Court. The Sixth Circuit also erred in its statement concerning the need to join the insurance company as an indispensable party. Code of Federal Regulation title 42

section 421.5(b) (1997) provides that intermediaries and carriers act on behalf of HCFA in carrying out certain administrative responsibilities and that HCFA is the real party of interest in any litigation involving the administration of the program. The Sixth Circuit implied that the intermediary should have been joined in the suit as an indispensable party, a direct contradiction to the Secretary's own regulation. *Your Home*, No. 96-5525, 9 n.2, App. 1. This statement appears to invite litigation against the insurance companies on an individual basis.

### III. The government's position cannot be substantially justified.

Finally, the petitioner would urge this Court to consider the Equal Access to Justice Act, 5 U.S.C. § 504 (West 1996) and 28 U.S.C. § 2412 (West 1996), in regard to this matter. If the petitioner is successful and eventually prevails in this case, the Equal Access to Justice Act would allow an award of attorneys' fees where the position of the United States was not substantially justified. Whether or not the position of the United States was substantially justified should be considered on the basis of the record which is made in the civil action for which fees and other expenses are sought. The test of whether the government's position is substantially justified is one of reasonableness in law and in fact and the United States has the burden of proof with regard to a showing of substantial justification for its position. *Foley Construction Co. v. U.S. Army Corps of Engineers*, 716 F.2d 1202, 1204 (8th Cir. 1983). This standard is said to represent a middle ground between an automatic award of fees and an award only in

circumstances where the government's position was frivolous. H.R. Rep. No. 96-1418, at 14, *reprinted in* 1980 U.S. Code Cong. & Ad. News 4993. The government's position in this case is not substantially justified where there was a secret salary survey discovered that revealed the petitioner's owners should have been paid the owners' compensation they claimed was reasonable. The petitioner's providers had filed administrative appeals related to owners' compensation for 1987, 1990, 1991, 1992, 1993, and 1994. All of these appeals were settled in October 1996 by the intermediary and additional owners' compensation was allowed. (See letters of settlement, App. 55.) The only year which the intermediary has refused to pay additional owners' compensation is the year for which a request to reopen was required because an administrative appeal had not been made. In other words, the intermediary has agreed that the owners were not paid the appropriate amount of owners' compensation for the years of 1987, 1990, 1991, 1992, 1993, and 1994. These cases were settled before the scheduled hearings dates at the Provider Reimbursement Review Board. (In 1988, there were no audit adjustments made to disallow any portion of owners' compensation.) In 1989, the year for which the request for reopenings were made and denied, there was no appeal for Board review requested within the 180 days of receipt of the initial Notice of Program Reimbursement Letters since the owners had not yet discovered the secret salary survey which revealed that competitors were paid more than the petitioner's owners. It was not until after the 180 days elapsed that the petitioner's providers discovered the secret salary survey which was the new and material evidence

that was the basis for the request for reopening of the 1989 cost reports. Because it is so clear that the intermediary is presently aware it paid the incorrect amount of owners' compensation for the petitioners owners for all of the years in question, including the 1989 year, the government's stance of continuing to refuse to reopen the cost reports to correct this error in the 1989 cost reports simply cannot be substantially justified.

It is inherently unfair for an employee of an insurance company to decide that some owners of home health agencies will not be paid as their competitors (who are virtually across the street) are paid. The reason for the discrepancy will never be known where the decision remains unreviewable. The insurance company employee who made this decision not to reopen the 1989 cost reports is not a member of the judiciary, not an elected official, not a lawyer, not a hearing officer. The individual is just a person with a job at an insurance company that has a contract to serve as a Medicare fiscal intermediary.

A person in such a position can be advised of mathematical errors on the settlement of a cost report and still refuse to reopen the cost report to make corrections. Even if the errors were caused by mistakes made by the intermediary, the cost report can still remain unopened. To sum up, no matter what the reason for the denial of reopening, there is no review, no appeal, no remedy, no justice in the Sixth Circuit. This leaves the power of law in the hands of one person working for an insurance company. This individual may not know what the Fifth Amendment to the United States Constitution guarantees. This person may not understand the phrase "due process" and the legal ramifications of that concept. Most

citizens in America expect to receive their day in court. In this situation, the Secretary of HHS and the Sixth Circuit have abolished that right. Instead, an employee of an insurance company will dispense or withhold justice. From this person's decision, there is no appeal. The government's position cannot be justified, and certainly cannot be "substantially justified."

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### CONCLUSION

The inconsistent treatment of Medicare providers has occurred because of the various interpretations of federal law. These disparities will continue within the districts unless this Court accepts this case and rules upon this issue. Providers in different geographic locations are receiving different measures of justice. The magnitude of the impact of these differences will continue to affect the providers nationwide until this controversy is resolved by one ruling which will govern all Medicare providers. Based upon the arguments and authorities presented herein, the petitioner respectfully requests careful consideration of this matter as appropriate for U.S. Supreme Court review.

Respectfully submitted,

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**APPENDIX A  
SIXTH CIRCUIT COURT CASE**

App. 1

RECOMMENDED FOR FULL-TEXT PUBLICATION

Pursuant to Sixth Circuit Rule 24

ELECTRONIC CITATION: 1997 FED App. 0366P (6th Cir.)

File Name: 97a0366p.06

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

YOUR HOME VISITING NURSE )  
SERVICES, INC., )

*Plaintiff-Appellant,* )

*v.* )

SECRETARY OF HEALTH AND )  
HUMAN SERVICES, )

*Defendant-Appellee.* )

No. 96-5525

Appeal from the United States District Court  
for the Eastern District of Tennessee at Knoxville.  
No. 95-00276 – Leon Jordan, District Judge.

Argued: June 5, 1997

Decided and Filed: December 22, 1997

Before: LIVELY, MERRITT, and SUHRHEINRICH,  
Circuit Judges.

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COUNSEL

ARGUED: Diane L. Gustin, Knoxville, Tennessee, for  
Appellant. Howard H. Lewis, SOCIAL SECURITY  
ADMINISTRATION, OFFICE OF GENERAL COUNSEL,  
Atlanta, Georgia, for Appellee. ON BRIEF: Diana L.  
Gustin, Knoxville, Tennessee, for Appellant. Howard H.  
Lewis, SOCIAL SECURITY ADMINISTRATION, OFFICE

OF GENERAL COUNSEL, Atlanta, Georgia, D. Gregory Weddle, OFFICE OF THE U.S. ATTORNEY, Knoxville, Tennessee, for Appellee.

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OPINION

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MERRITT, Circuit Judge. We are asked once again to review and construe federal health care statutes and regulations governing reimbursement to a "provider" of services.

The plaintiff, Your Home Visiting Nurse Service, Inc., provides home nursing services to Medicare beneficiaries and receives reimbursement from Medicare. This program is administered by the United States Department of Health and Human Services. As part of the reimbursement procedures, Your Home submits annual cost reports to Blue Cross and Blue Shield of South Carolina, a fiscal intermediary acting as the agent of defendant, the Secretary of Health and Human Service.

Your Home sought to reopen cost reports submitted to Blue Cross for fiscal year 1989 due to findings of "new and material" evidence that the reports should be modified. Blue Cross declined to reopen the cost reports. Your Home then appealed Blue Cross's denial to reopen the cost reports to the Provider Reimbursement Review Board. The Review Board found that it lacked jurisdiction to review a fiscal intermediary's decision not to reopen the plaintiff's 1989 cost reports. Your Home appealed the denial of jurisdiction by the Review Board to the district

court. The district court dismissed the complaint, upholding the Review Board's determination that it lacked jurisdiction and further holding that the district court did not have federal question or mandamus jurisdiction to review directly the fiscal intermediary's decision. A timely appeal to this Court followed. For the reasons set forth below, this Court affirms the judgment of the district court.

This appeal concerns four cost reports that Your Home submitted for the 1989 fiscal year. Blue Cross issued notices of program reimbursement pursuant to 42 C.F.R. § 405.1803 for these cost reports, setting out the reimbursement due and listing the expenses allowed and disallowed. Your Home did not appeal any of the four notices of program reimbursement to the Review Board within the 180-day appeal period specified by statute, 42 U.S.C. § 1395oo. Your Home, however, did file a timely request with Blue Cross to reopen the 1989 cost reports pursuant to 42 C.F.R. § 405.1885 on the ground that Your Home had discovered "new and material evidence" affecting its reimbursement. In particular, Your Home alleged that a prior fiscal intermediary calculated the applicable owner compensation rates incorrectly for the 1987 fiscal year, which then in turn affected the 1989 cost reports.

Your Home raises three issues on appeal: (1) whether the Provider Reimbursement Review Board has jurisdiction to review a fiscal intermediary's denial of a request to reopen a Medicare cost report; (2) whether the district court has federal question jurisdiction to review a fiscal intermediary's denial of a request to reopen a Medicare

cost report and (3) whether the district court has mandamus jurisdiction to review a fiscal intermediary's denial of a request to reopen a Medicare cost report. We will address each of these issues separately below.<sup>1</sup>

### 1. The Review Board's Jurisdiction

42 U.S.C. § 1395oo(a) states:

Any provider . . . which has filed a required cost report . . . may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if [in addition to other requirements that are not at issue] (1) such provider (A)(i) is dissatisfied with a final determination of the . . . fiscal intermediary . . . as to the amount of total program reimbursement due the provider. . . .

Your Home's argument turns on whether a fiscal intermediary's denial of a request to reopen is unambiguously a "final determination . . . as to the amount of total program reimbursement due the provider" within the plain meaning of that phrase.

<sup>1</sup> On April 3, 1997, Your Home filed a Motion to Request Addition of Document as Exhibit. The "document" is actually two letters purporting to resolve outstanding cases between Blue Cross/Blue Shield and Your Home through an "Administrative resolution." On April 10, 1997, the Secretary filed an objection to Your Home's Motion. Because the documents were not considered by the District Court, we will not consider them here in the first instance. Moreover, the documents do not address the year at issue in this case (1989) and, even if we were to consider the documents filed by Your Home, they would not alter our holding here.

The reopening procedure was created by regulation rather than statute. The Medicaid statute does not require, or even mention, a reopening procedure. Nevertheless, the regulations promulgated by the Secretary specify that a fiscal intermediary's determination "*may* be reopened" (emphasis added) when a request to reopen is made within three years of the determination. 42 C.F.R. § 405.1885(a). The regulations specify, however, that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R. § 405.1885(c). The criteria for reopening are set forth in the Provider Reimbursement Manual, which provides:

Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions.

Provider Reimbursement Manual § 2931.2.

Although the regulations specify that new determinations after a cost report has been reopened are subject to review in the same manner as initial decisions, 42 C.F.R. § 405.1889, the regulations are silent as to whether a decision not to reopen is subject to review. The Provider Reimbursement Manual, however, states: "A refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board. . . ." Provider Reimbursement Manual, Appendix A, ¶ B.4.

The Provider Reimbursement Review Board found that it lacked jurisdiction based on the above language in

the Provider Reimbursement Manual. The district court affirmed, construing the Provider Reimbursement Manual language as an interpretive rule pursuant to *Shalala v. Guernsey Mem. Hosp.*, 514 U.S. 87 (1995), and deferring to the Secretary's interpretation of the Review Board's jurisdiction pursuant to *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). At least two circuit courts have also held that the Review Board does not have jurisdiction over refusals to reopen based on the language in the Manual. *Good Samaritan Hosp. Reg'l Med. Ctr. v. Shalala*, 85 F.3d 1057 (2d Cir. 1996); *Athens Community Hosp., Inc. v. Schweiker*, 743 F.2d 1, 4 n.1 (D.C. Cir. 1984); *Saint Mary of Nazareth Hosp. Ctr. v. Schweiker*, 741 F.2d 1447 (D.C. Cir. 1984) (when fiscal intermediary reopens with respect to some, but not all, issues, Provider Reimbursement Review Board lacks jurisdiction to review partial denial of reopening).

Your Home argues that deference to the Secretary's interpretation in the Manual is inappropriate here because that interpretation is contrary to the plain meaning of the statute. In particular, Your Home argues that a denial of a reopening request is plainly a "final determination" as that phrase is used in the statute. Your Home attempts to bolster this argument by relying on the presumption that administrative actions are subject to judicial review. See *Bowen v. Michigan Academy*, 476 U.S. 667, 670 (1986).

In *Good Samaritan Hospital*, the Second Circuit explained its holding as follows:

the plain meaning of [42 U.S.C.] § 1395oo(a) does not compel a holding that a reopening denial is a 'final determination' of the amount of

total program reimbursement. To the contrary, we believe that the statute may be construed permissibly as stating that a reopening denial is a refusal to revisit the final determination. . . . [W]hile . . . a decision not to reopen is in some sense 'final,' it does not, in and of itself, establish an amount of total program reimbursement [as required by the statute]. Instead it is a final determination that there are not grounds on which to reconsider a previous final determination as to the amount of total program reimbursement.

*Good Samaritan Hosp.*, 85 F.3d at 1061 (quoting *Good Samaritan Hosp. Reg'l Med. Ctr. v. Shalala*, 894 F.Supp. 683 (S.D.N.Y. 1995)). In light of this statutory ambiguity, deference to the Secretary's regulations and interpretations is appropriate.

This conclusion is bolstered by the Supreme Court's holding in *Califano v. Sanders*, 430 U.S. 99 (1977). In *Sanders*, an Administrative Law Judge denied a social security disability claimant's request to reopen a claim and the claimant sought judicial review. The claimant argued that the district court had jurisdiction pursuant to section 205(g) of the Social Security Act, which provides: "Any individual, after any final decision of the Secretary made after a hearing to which he was a party . . . may obtain a review of such decision by a civil action commenced within sixty days. . . ." 42 U.S.C. § 405(g). The Supreme Court held that this did not confer jurisdiction because the Social Security Act does not require hearings on petitions to reopen. Moreover, the Court suggested that there would be no federal court jurisdiction even if

the Secretary promulgated regulations allowing for hearings on such petitions:

[T]he opportunity to reopen final decisions and any hearing convened to determine the propriety of such action are afforded by the Secretary's regulations and not by the Social Security Act. Moreover, an interpretation that would allow a claimant judicial review simply by filing and being denied a petition to reopen his claim would frustrate the congressional purpose . . . to impose a 60-day limitation upon judicial review of the Secretary's final decision on the initial claim for benefits.

*Sanders*, 430 U.S. at 108.

The Medicare statute, similar to the Social Security Act, does not require the Secretary to afford Medicare providers an opportunity for rehearing of fiscal intermediaries' determinations. Therefore, even if our task in this case were to construe the statute at issue without benefit of the Secretary's interpretation in the Manual, *Sanders* suggests that the proper interpretation would be to avoid frustrating the congressional purpose to impose a 180-day limitation upon Provider Reimbursement Review Board review of a fiscal intermediary's final determination on an initial cost report by holding that the statute does not confer jurisdiction on the Review Board to conduct such a review. The Secretary's interpretation of the Medicare statute in the Manual is reasonable in light of *Sanders*. If that interpretation is not foreclosed by the plain language of the statute, and we find it is not, we must defer to it pursuant to *Chevron*.

Your Home, relying on *Powderly v. Schweiker*, 704 F.2d 1092 (9th Cir. 1983), argues that this Court should not defer to the Secretary's interpretation in the Provider Reimbursement Manual because that interpretation is a substantive rule and substantive rules must be promulgated in accordance with the Administrative Procedure Act's notice and comment period requirements, which was not done here. The rule in question, however, is an interpretive rule and the Administrative Procedure Act exempts interpretive rules from its notice and comment requirements. 5 U.S.C. § 553(b)-(c). As the *Powderly* court explained, "[s]ubstantive rules are those which effect a change in existing law or policy. Interpretive rules are those which merely clarify or explain existing law or regulations." *Powderly*, 704 F.2d at 1098. As in *Powderly*, the Manual provision at issue here does not change any existing law or policy and does not remove any previously existing rights of Medicare providers. It merely explains "what the more general terms of the Act and regulations already provide." *Id.* The Manual merely provides an interpretive rule. As the Supreme Court recently held, such agency interpretive rules are subject to deference when they are not contrary to statute. See *Shalala v. Guernsey Mem. Hosp.*, 514 U.S. 87 (1995).

Your Home's reliance on the presumption that federal courts have jurisdiction to review administrative decisions is also unavailing. Although the *Sanders* Court did not address that presumption explicitly, the *Sanders* decision suggests that the presumption does not apply to administrative proceedings not required by statute that expand a claimant's opportunity for administrative

review beyond statutory requirements that, in themselves, provide adequate opportunities for judicial review. Your Home could have obtained judicial review of the fiscal intermediary's final decision on its initial claim by filing an appeal with the Review Board within 180 days of that decision and continuing with further appeals, if necessary, as provided in the Medicare statute. Those statutory procedures are adequate to preserve judicial review. As in *Sanders*, the Secretary is entitled to create a reopening procedure to provide even greater protection to providers than required by statute without having to incur the additional expense entailed by full administrative and judicial review of refusals of requests to reopen.

## 2. Federal Question Jurisdiction

Your Home argues that even if the Provider Reimbursement Review Board lacked jurisdiction to consider Your Home's appeal, the district court had either federal question jurisdiction or mandamus jurisdiction to review directly the fiscal intermediary's refusal to reopen. Your Home therefore requested as relief an order directing the fiscal intermediary, Blue Cross, to reopen the cost reports at issue.<sup>2</sup>

<sup>2</sup> We note that, despite this request for relief, Your Home failed to join Blue Cross in the suit. Although not addressed by the court below, this may constitute a failure to join an indispensable party. If that is so, the district court could have ordered that Blue Cross be joined as a party or, if that was not possible, dismissed the suit on that basis. Fed. R. Civ. P. 19. Because neither the district court nor the Secretary raised the failure to join an indispensable party, we will not base our holding on that issue.

The applicable regulations limit judicial review of the Secretary's decisions. 42 U.S.C. § 1395ii provides:

[t]he provisions of . . . subsection[ ] . . . (h) . . . of section 405 of this title, shall also apply with respect to this subchapter . . . except that, in applying such provisions with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

42 U.S.C. § 405(h) provides:

No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Your Home argues that "claim" as used in § 405(h) is a term of art referring to a Medicare claim for reimbursement and that collateral challenges not requiring consideration of the merits are outside the scope of the statute.

Your Home's argument is foreclosed by *Heckler v. Ringer*, 466 U.S. 602 (1984). In *Ringer*, the Secretary of Health and Human Services issued an administrative ruling that Medicare did not cover a certain surgical procedure. Four individual claimants brought a suit challenging the ruling, asserting federal question jurisdiction. The Court held that § 405(h) barred the suit, finding that "the inquiry in determining whether § 405(h) bars

federal question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." *Id.* at 614-15. The proper test is whether " 'both the standing and the substantive basis for the presentation' of the claims" is the Medicare statute. *Id.* at 615 (quoting *Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975)). See also *Califano v. Sanders*, 430 U.S. 99 (1977) (§ 405(h) precludes federal question jurisdiction).

Here both the standing and the substantive basis for the presentation of Your Home's claims comes from the plain language of the Medicare statute. Therefore § 405(h) precludes federal question jurisdiction.<sup>3</sup>

### 3. Mandamus Jurisdiction

Finally, Your Home argues that the district court had mandamus jurisdiction to review Blue Cross' failure to reopen. Section 405(h) explicitly precludes jurisdiction pursuant to 28 U.S.C. §§ 1331 & 1346, but does not mention the mandamus statute, 28 U.S.C. § 1361. The Supreme Court has explicitly left open the question of whether or not § 405(h) precludes mandamus jurisdiction. See, e.g., *Califano v. Yamasaki*, 442 U.S. 682 (1979). Several

<sup>3</sup> Your Home's reliance on *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), is unavailing. *Michigan Academy* concerned a Part B Medicare provider. Jurisdictional questions arising from Part B claims are now treated in this Circuit identically to such questions arising under Part A, so *Michigan Academy's* amount/methodology distinction no longer has force. *Farkas v. Blue Cross & Blue Shield*, 24 F.3d 853, 860 (6th Cir. 1994).

courts, however, have held that mandamus jurisdiction exists over challenges to the Secretary's procedural rules. See *Ellis v. Blum*, 643 F.2d 68, 78 (2d Cir. 1981); *Frost v. Weinberger*, 515 F.2d 57, 62 (2d Cir. 1975); *Knuckles v. Weinberger*, 511 F.2d 1221, 1222 (9th Cir. 1975); *Martinez v. Richardson*, 472 F.2d 1121, 1125-26 (10th Cir. 1973).

Mandamus jurisdiction is available only if (1) the plaintiff has exhausted all available administrative appeals and (2) the defendant owes the plaintiff a "clear nondiscretionary duty" that it has failed to perform. *Heckler v. Ringer*, 466 U.S. 602, 616. The district court found that Your Home failed to exhaust administrative appeals because it failed to appeal Blue Cross' initial decision within 180 days, not the decision not to reopen the cost reports. The district court also held that there was no violation of a clear non-discretionary duty because the Secretary has discretion over the decision whether or not to reopen a cost report based on "new and material evidence."

The district court's holding with respect to exhaustion is incorrect. Your Home's failure to appeal the initial determination would preclude mandamus review of that determination, but does not preclude review of a decision not to reopen. Your Home has exhausted all available remedies with respect to its claim that Blue Cross improperly denied its request to reopen.

With respect to the existence of a nondiscretionary duty, the relevant regulation states:

A determination of an intermediary . . . may be reopened . . . by such intermediary officer . . . on

motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

42 C.F.R. § 405.1885(a) (emphasis added). In addition, the Provider Reimbursement Manual provides:

Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether (1) new and material evidence has been submitted, (2) a clear and obvious error was made, or (3) the determination is found to be inconsistent with the law, regulations and rulings, or general instructions.

Provider Reimbursement Manual § 2931.2.

In *Good Samaritan Hospital Regional Medical Center v. Shalala*, 894 F.Supp. 683 (S.D.N.Y. 1995), *aff'd on other grounds*, 85 F.3d 1057 (2d Cir. 1996), the court, after reviewing these provisions, concluded that the fiscal intermediary's reopening determination is discretionary because the regulation says only that the fiscal intermediary "may" reopen, and the manual merely lists the factors that must be considered, without specifying that reopening must be granted if those factors are present.

The district court looked to the Secretary in determining the existence of a nondiscretionary duty. The district court looked to the wrong party under the language in the regulation. Although the Secretary has discretion over whether to allow reopenings, the proper question is whether Blue Cross, the fiscal intermediary, had a nondiscretionary duty to reopen pursuant to the Secretary's regulations and interpretations thereof. As noted above, Blue Cross was not a party to this action. However, even if Blue Cross had been joined as a party, its decision not

to reopen was discretionary based on *Good Samaritan Hospital* and would not have triggered mandamus jurisdiction. Therefore, the district court properly found that it did not have mandamus jurisdiction, even though its analysis was incorrect.

For the foregoing reasons, we AFFIRM the judgment of the district court.

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**APPENDIX B**  
**DISTRICT COURT DECISION**

App. 16

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF  
TENNESSEE AT KNOXVILLE

YOUR HOME VISITING	)	
NURSE SERVICES, INC.,	)	
Plaintiff,	)	No. 3:95-cv-276
v.	)	(Filed Mar. 22, 1996)
SECRETARY OF HEALTH	)	
AND HUMAN SERVICES,	)	
Defendant.	)	

ORDER

For the reasons stated in the Memorandum Opinion filed contemporaneously with this Order, it is hereby ORDERED that the defendant's motion to dismiss or, in the alternative, for summary judgment [doc. 5] is GRANTED, and all claims against the defendant are DISMISSED.

ENTER:

/s/ Leon Jordan  
Leon Jordan  
United States District Judge

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IN THE UNITED STATES DISTRICT COURT FOR THE  
EASTERN DISTRICT OF TENNESSEE  
AT KNOXVILLE

YOUR HOME VISITING NURSE	)	
SERVICES, INC.,	)	
Plaintiff,	)	
	)	No. 3:95-cv-276
v.	)	
SECRETARY OF HEALTH	)	(Filed
AND HUMAN SERVICES,	)	March 22, 1996)
Defendant.	)	

MEMORANDUM OPINION

This civil matter is before the court on the defendant's motion to dismiss or in the alternative for summary judgment [docs. 5 and 6]. The plaintiff has responded [doc. 7], and the defendant has replied [doc. 9]. Oral argument was heard on the defendant's motion and thus, the motion is ripe for the court's consideration. For the reasons stated below, the court finds the defendant's motion well-taken, and the complaint must be dismissed.

The issue in this case arising under the Medicare statute is whether the refusal of a fiscal intermediary to reopen a Medicare service provider's cost report is administratively or judicially reviewable. The Sixth Circuit Court of Appeals has not addressed this issue, and there is a split of opinion among the other circuit courts of appeal.

The plaintiff in this case is a service provider under the Medicare program. The complaint seeks a review of

the determination by the Provider Reimbursement Review Board (PRRB) that it had no jurisdiction to reconsider the decision of the fiscal intermediary, Blue Cross and Blue Shield of South Carolina (BCBS/SC), to not reopen the plaintiff's 1989 cost report. The plaintiff asks this court to reverse the PRRB's decision that it had no jurisdiction and either remand the case back to the PRRB so it can review BCBS/SC's decision not to reopen the cost report or to make a finding that BCBS/SC erred in not reopening the cost report. In its response to the defendant's motion, the plaintiff has withdrawn its request that the court determine the amount of compensation due the plaintiff and concedes that this is a decision for BCBS/SC to make.

I. BACKGROUND

A. Relevant Statutes and Regulations

The Medicare program was established by Congress to provide a system of health insurance for the aged and disabled. 42 U.S.C. § 1395 *et seq.* The program is divided into two parts: Part A which provides insurance for inpatient institutional services, home health services and post-hospital services, 42 U.S.C. §§ 1395c and 1395d; and Part B which covers physician, outpatient hospital, and other health services, 42 U.S.C. §§ 1395j, 1395l and 1395x. Home health care agencies (providers), such as the plaintiff in this case, participate in the Medicare program by entering into provider agreements with the Secretary. 42 U.S.C. § 1395h. Under these agreements, the provider agrees to provide Medicare beneficiaries with services

and seek reimbursement from private insurance companies (fiscal intermediaries) who act as agents of the Secretary.

At the end of a provider's fiscal year, the provider is required to file a cost report with the fiscal intermediary. 42 C.F.R. § 413.20(b). The fiscal intermediary analyzes the cost report and furnishes the provider with a notice of program reimbursement (NPR) which sets out the reimbursement due the provider and lists the expenses allowed and disallowed. 42 C.F.R. § 405.1803.

The NPR also advises the provider of its appeal rights. *Id.* If the provider is dissatisfied with the NPR and the amount in controversy is \$10,000 or more, it may request a hearing before the PRRB within 180 days of the issuance of the NPR. 42 U.S.C. § 1395oo. The PRRB may affirm, modify or reverse the decision of the fiscal intermediary. *Id.* The Secretary may then review the PRRB decision within sixty days. If the provider is still dissatisfied, then the provider may seek judicial review in the United States district court within sixty days of the final decision. *Id.*

If the provider does not appeal the final cost report determination within 180 days, the cost report is closed and the amount of reimbursement is not subject to further review. However, the Medicare regulations permit one exception to this timetable; that is, the Secretary or the provider may seek to have the fiscal intermediary reopen the cost report within three years of the fiscal intermediary's decision. (The three-year limitation may be waived if the decision "was procured by fraud or

similar fault of any party.") 42 C.F.R. § 405.1885. Reopenings require a showing that there is new and material evidence to be submitted, that clear or obvious error was made, or the original decision was inconsistent with the law. Provider Reimbursement Manual (PRM) (HIM-15) § 2931.2. Neither the Medicare regulations nor the PRM provide a mechanism for appealing a denial of a reopening request, and it is this lack of authorization for an appeal which creates the issue in this case.

#### B. Procedural History

On March 29, 1991, BCBS/SC issued four NPR's to the plaintiff's four agencies for the fiscal year 1989. Each NPR informed the plaintiff that it had 180 days to appeal the determination of BCBS/SC. The plaintiff did not file administrative appeals with PRRB within 180 days. During the course of appealing later NPR's, the plaintiff discovered that BCBS/SC had set a base rate for the plaintiff's owner compensation by comparing plaintiff's owner compensation rate to individual agencies rather than chain operations such as plaintiff's. The plaintiff alleges that this resulted in a base salary rate which was much lower than its owners were entitled.

Upon discovery of this information, the plaintiff sought to have BCBS/SC reopen the cost reports for fiscal year 1989, claiming that it had new and material evidence to submit for the intermediary's consideration. BCBS/SC declined to reopen the cost reports and the plaintiff attempted to appeal this decision with the PRRB. The PRRB determined that it did not have jurisdiction over a decision not to reopen a cost report because a decision

not to reopen a cost report is not a "final determination" within the meaning of the statute and regulations. The plaintiff then filed this action asking this court to review the PRRB's decision.

## II. DISCUSSION

### A. Standard of Review

Pursuant to 42 U.S.C. § 1395oo(f)(1), a decision by the PRRB is subject to review in accordance with the Administrative Procedures Act (Chapter 7 of Title 5, United States Code). A court may set aside a final agency action only if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A); see also, *Thomas Jefferson Univ. v. Shalala*, \_\_\_ U.S. \_\_\_, 114 S.Ct. 2381, 2386, 129 L.Ed.2d 405 (1994). This standard of review is considered to be "highly deferential." See *Binghamton Gen. Hosp. v. Shalala*, 856 F. Supp. 786, 792 (S.D.N.Y. 1994). A court should give substantial deference to an agency's construction of a statutory scheme it is entrusted to administer. See *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844, 104 S.Ct. 2778, 2782, 81 L.Ed.2d 694 (1984); *Binghamton*, 856 F. Supp. at 792.

Where Congress has expressly authorized an agency to promulgate regulations, as it has with the Medicare scheme, "[s]uch legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Chevron*, 467 U.S. at 844, 104 S.Ct. at 2782. Further, an agency's interpretation of its regulations is entitled to great deference unless the interpretation is plainly erroneous or inconsistent with the

underlying regulation or statute. See *Thomas Jefferson Univ.*, 114 S.Ct. at 2386. This is especially true when the regulations concern "a complex and highly technical regulatory program" such as the Medicare program. *Id.* at 2387 (quoting *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988)).

In its motion to dismiss or for summary judgment, the defendant argues that, under Sixth Circuit law, this court's review is limited to whether the PRRB erred in determining that it lacked jurisdiction. *Saline Community Hosp. v. Secretary of Health and Human Services*, 744 F.2d 517 (6th Cir. 1984). In *Saline*, the plaintiffs attempted to amend their cost reports to include an additional amount for reimbursement after the deadline for filing their cost reports. *Id.* at 518. The fiscal intermediaries rejected the proposed amendments because the amendments did not "revise" the cost report information previously submitted.<sup>1</sup> The PRRB declined to hear the plaintiffs' appeals because it determined that its jurisdiction was limited to a review of the fiscal intermediary's determination on the cost reports and matters covered therein. *Id.* at 519. Since the cost reports did not have the proposed amendments, the PRRB declined jurisdiction. *Id.* The Sixth Circuit stated that the PRRB "properly refused the requests for hearings." *Id.* The court found that the PRRB's finding of no jurisdiction was a final decision subject to judicial review, but judicial review was limited to that issue

<sup>1</sup> The regulation provides: "Amended cost reports to revise cost report information which has been previously submitted may be permitted or required as determined by the Health Care Financing Administration." 42 C.F.R. § 405.435(f).

alone. "The district court could not rule on the *merits* of the claim over which the Board declared it lacked jurisdiction, only on whether the Board's jurisdictional decision was correct." *Id.* at 520 (emphasis in original).

In its response, the plaintiff appears to agree that this is the correct "scope of review" for this court, and avers that it "does not ask this Court to rule upon the merits of the claim. If this court finds the Board was incorrect in the decision that it lacked jurisdiction, the case should be remanded back to the Board." *See* doc. 7, at p. 5. However, the plaintiff then states:

In the alternative, the plaintiff asked this Court to make its own finding that the intermediary abused its discretion in refusing to re-open the 1989 cost report and to order the intermediary to re-open the cost report to review the new and material evidence concerning the previous intermediary's use of a salary survey for owners' compensation which was not comparable to the owners of the plaintiff's chain operation. . . .

Doc. 7, at pp. 5-6. The plaintiff argues that this request is not for a ruling on the merits.

The court disagrees. Any finding that this court might make concerning whether the intermediary abused its discretion in failing to reopen the 1989 cost report would be, in fact, a ruling on the merits of the claim since this court would have to decide whether the plaintiff's evidence was new and material. The PRRB determined that it did not have jurisdiction over BCBS/SC's decision not to reopen, and under *Saline*, this court's review is limited to a review of the PRRB's determination. *See also Binghamton*, 856 F. Supp. at 793.

#### B. Review of the PRRB's Decision

In her motion to dismiss or for summary judgment, the Secretary argues that the PRRB's decision that it did not have jurisdiction was correct. The Secretary submits that her agency's regulations and the Provider Reimbursement Manual support this view.

Section 1395oo(a) of Title 42, United States Code, provides, in relevant part:

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if -

(1) such provider -

(a)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary . . .

. . . .

(2) the amount in controversy is \$10,000 or more, and

(3) such provider filed a request for a hearing within 180 days after notice of the intermediary's final determination. . . .

Thus, the question for this court is whether a decision by the fiscal intermediary not to reopen is a final determination since the PRRB only has jurisdiction over final determinations. It must be noted again that the statute does not address reopening procedures; the reopening procedures are found only in the implementing regulations. The regulations state that a provider affected by a determination of the intermediary, the

PRRB, or the Secretary may move to reopen the determination or decision to revise any matter in issue. 42 C.F.R. § 405.1885(a). The regulations provide that when an intermediary decision is reopened *and revised*, the revision will be considered to be an appealable final determination. But, subpart (c) provides: "Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 U.S.C. § 405.1885(c).

The Secretary has expressed her interpretation of this portion of the regulations in the Provider Reimbursement Manual. Appendix A to the PRM states at paragraph 4:

*Refusal to Reopen.* – A refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 CFR § 405.1885(c), except for providers which are located within the jurisdiction of the U.S. Ninth Circuit Court of Appeals, where such refusal to reopen is appealable. . . . "

As pointed out by the defendant, the Supreme Court recently has indicated that manual provisions are an appropriate means for the Secretary to express her interpretation of the regulations. See *Shalala v. Guernsey Memorial Hospital*, \_\_\_ U.S. \_\_\_, 115 S.Ct. 1232, 131 L.Ed.2d 106 (1995).

The plaintiff argues that the regulation cited above is a substantive rule which was not promulgated in accordance with the notice and comment period required by the APA and, therefore, should not be enforced. In her reply brief, the defendant submits that "[i]t is hard to imagine a better example of an interpretive rule than § 2932.1 which simply rephrases a regulation, 42 C.F.R.

§ 405.1885(c). The court agrees. The manual rules are clearly interpretive of the regulations and given to providers to help them comply with the Secretary's regulations.

The Sixth Circuit has not addressed whether the intermediary's decision not to reopen a cost report is a final determination subject to appeal to the PRRB, and there is a difference of opinion among the other circuits. For example, the Circuit Court of Appeals for the District of Columbia has held that 42 C.F.R. § 405.1885(c) makes denials of reopenings unappealable. See, e.g., *St. Mary of Nazareth Hosp. Ctr. v. Schweiker*, 741 F.2d 1447, 1449 (D.C. Cir. 1984). The District Court for the Southern District of New York has come to this same conclusion. See *Good Samaritan Hosp. Regional Medical Ctr. v. Shalala*, 894 F. Supp. 683, 695 (S.D.N.Y. 1995); *Binghamton*, 856 F. Supp. at 799. To the contrary, the Ninth Circuit Court of Appeals has found that the PRRB could review a refusal by the intermediary to reopen a cost report.<sup>2</sup> See *State of Oregon v. Bowen*, 854 F.2d 346, 349-40 (9th Cir. 1988).

Obviously, the plaintiff urges this court to follow the Ninth Circuit. However, this court finds that the Secretary's determination as reflected in the Medicare regulations and Provider Reimbursement Manual that denials of reopening requests are unreviewable is a reasonable interpretation of the Medicare statute.

The court finds the District Court's opinion in *Binghamton* very beneficial. In *Binghamton*, the issue before the

<sup>2</sup> This result is reflected in the language of the PRM quoted above.

District Court for the Southern District of New York was nearly identical to the issue here: whether the PRRB had jurisdiction to review a decision by the fiscal intermediary not to reopen cost reports and allow evidence of reimbursement for malpractice insurance. The court undertook a careful review of the statutes, regulations and the manual provisions and determined that the PRRB was correct in its determination that it did not have jurisdiction to review reopening decisions. *Binghamton*, 856 F. Supp. at 799.

The court first determined that a decision not to reopen is not a final determination within the meaning of the statute (42 U.S.C. § 1395oo). *Id.* at 795. The court recognized that the statute is ambiguous but decided that the most reasonable interpretation is that denials of reopening are not appealable final determinations. The court reasoned that an intermediary's decision not to reopen a cost report is "basically a decision not to disturb its previous decision. As such, it is akin to the decision of a judicial panel or en banc court to deny rehearing, and 'no one supposes that that denial, as opposed to the panel opinion, is an appealable action.'" *Id.* at 794 (quoting *ICC v. Brotherhood of Locomotive Engineers*, 482 U.S. 270, 280, 107 S.Ct. 2360, 2366, 96 L.Ed.2d 222 (1987)).

Since the *Binghamton* court determined that the statute was ambiguous, the court looked next to the Secretary's reopening regulations. *Binghamton*, 856 F. Supp. at 796. The court discussed 42 C.F.R. § 405.1885(c) (quoted above) and stated:

To the extent that there is any ambiguity in § 405.1885(c)'s assertion that jurisdiction for

reopening "rests exclusively" with the reopening agency, this is put to rest in the manual, which expressly precludes review of intermediaries' decisions denying reopening. . . . The Secretary's interpretation of the regulations as set forth in the PRM is entitled to deference.

*Id.* at 797.

Finally, the court looked at the Ninth Circuit case which has come to the opposite conclusion and found that the decision was flawed in several respects. First, the court noted that the Ninth Circuit failed to consider the policies and procedures set by the Secretary in the PRM. *Id.* Second, the court noted that the Ninth Circuit failed to read § 405.1885(c) in context with the other reopening regulations, specifically, there is no regulation authorizing review of reopening denials comparable to § 405.1889 which provides for review of *revised* cost reports after reopening. *Id.* at 798. The court stated that this demonstrates a decision by the Secretary to make reopening denials unreviewable. *Id.* Finally, the *Binghamton* court found the Ninth Circuit's policy reasons unpersuasive. The Ninth Circuit found that there must be judicial review of reopening denials under the general presumption that agency action should be reviewable. See *State of Oregon*, 854 F.2d at 350. However, the *Binghamton* court recognized that the Supreme Court rejected a challenge to a reopening denial in the context of the Social Security program. See *Califano v. Sanders*, 430 U.S. 99, 104, 97 S.Ct. 980, 984, 51 L.Ed.2d 192 (1977).

In *Sanders*, the Supreme Court was called upon to decide if judicial review was available after the Secretary (of Health, Education and Welfare) declined to reopen a

claim for benefits under the Social Security Act.<sup>3</sup> Like the statutory and regulatory scheme for Medicare, only the Social Security regulations provided for a reopening mechanism. The Court recognized that "judicial review should be widely available to challenge the actions of federal administrative officials." *Sanders*, 430 U.S. at 104, 97 S.Ct. at 984. However, the Court went on to hold that section 405(g) of Title 42, United States Code, clearly limited judicial review to "final decisions." *Id.* 430 U.S. at 108, 97 S.Ct. at 986. The Court stated: "[A]n interpretation that would allow a claimant judicial review simply by filing – and being denied – a petition to reopen his claim would frustrate the congressional purpose, plainly evidenced in [§ 405(g)], to impose a 60-day limitation upon judicial review of the Secretary's final decision on the initial claim for benefits." *Id.*

The *Binghamton* court concluded by holding that the "Secretary's determination, in the Medicare regulations and the Provider Reimbursement Manual, that denials of reopening requests are unreviewable is a reasonable interpretation of the Medicare statute." *Binghamton*, 856 F. Supp. at 799. This court agrees and finds that the PRRB's decision that it lacked jurisdiction was correct. The defendant's motion to dismiss or for summary judgment on this issue must be granted.

<sup>3</sup> See *Rhode Island Hosp. v. Califano*, 585 F.2d 1153 (1st Cir. 1978) (finding that 42 U.S.C. 405(g) is the "functional equivalent" of section 1395oo).

### C. Plaintiff's Alternate Bases for Jurisdiction

The plaintiff also claims that this court has federal question and mandamus jurisdiction. The defendant argues that federal question jurisdiction has been statutorily rejected and mandamus relief is not available because the plaintiff cannot demonstrate that it exhausted all avenues of relief or that the Secretary owes it a non-discretionary duty.

First, on the issue of federal question jurisdiction (28 U.S.C. § 1331), the applicable statute is 42 U.S.C. § 1395ii. That statute specifically incorporates § 405(h) of Title 42 into the Medicare program statutes. Section 405(h) provides:

The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28, United States Code, to recover on any claim arising under this subchapter.

The defendant argues that since the plaintiff's claim is brought under the Medicare Act, this statute precludes federal question jurisdiction. See *Heckler v. Ringer*, 466 U.S. 602, 614, 104 S.Ct. 2013, 2021, 80 L.Ed.2d 622 (1984). If, as the defendant argues, the plaintiff's claim arises under the Medicare Act, then the plaintiff's only avenue to judicial review is found at 42 U.S.C. § 1395oo. The defendant argues that since the plaintiff did not avail

itself of the remedies available under § 1395oo, the plaintiff cannot rely on federal question jurisdiction.

The plaintiff attempts to distinguish its claim as one for which federal question jurisdiction might lie. Relying upon *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986), the plaintiff argues that since it is not seeking review of the reimbursement claim itself, this court has federal question jurisdiction over the reopening denial. However, in *Michigan Academy*, the plaintiffs were challenging the validity of a regulation. The Supreme Court stated that this type of action was not a claim arising out of the Medicare Act; in other words, the plaintiffs were not seeking to have a claim adjudicated.

This is not the situation in the present case. Ultimately, the plaintiff is seeking review of its claim for increased owners' compensation, although there were some procedural hurdles along the way. As the Supreme Court in *Ringer* noted, even though the plaintiff complains about the Secretary's procedures, that complaint is "inextricably intertwined" with the plaintiff's claim for increased owners' compensation. *Ringer*, 466 U.S. at 614, 104 S.Ct. at 2021. "[T]o be true to the language of the statute, the inquiry in determining whether § 405(h) bars federal-question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." *Id.* at 615, 104 S.Ct. at 2021.

The court finds that the plaintiff's claim "arises under" the Medicare Act, since it is, at bottom, a claim for increased compensation. See *Good Samaritan Hosp.*

*Regional Medical Ctr. v. Shalala*, 894 F. Supp. 683, 695 (S.D.N.Y. 1995) (considering a nearly identical issue and finding that the claims arise under the Medicare statute). The court finds that federal question jurisdiction is not available to the plaintiff.

Next, in its complaint the plaintiff also suggests that this court has mandamus jurisdiction (28 U.S.C. § 1361). The defendant argues that this court does not have mandamus jurisdiction either because the plaintiff has not exhausted all avenues of relief (the plaintiff failed to appeal the NPR within 180 days) and the plaintiff cannot show that the defendant owes the plaintiff a clear, non-discretionary duty (whether to reopen to reopen [sic] the cost report to consider the plaintiffs' "new and material" evidence is matter within the discretion of the Secretary). See *Ringer*, 466 U.S. at 616-17, 104 S.Ct. at 2022-23; *Good Samaritan*, 894 F. Supp. at 695-96. The plaintiff has not responded to this portion of the defendant's argument.

The court finds the defendant's argument that this court does not have mandamus jurisdiction well-taken, and the plaintiff's jurisdictional claim on this basis must be denied.

III. CONCLUSION

For the reasons stated above, the defendant's motion to dismiss or for summary judgment is granted and the plaintiff's claims are dismissed.

ENTER:

/s/ Leon Jordan  
Leon Jordan  
United States District Judge

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**APPENDIX B  
PROVIDER REIMBURSEMENT REVIEW BOARD  
DISMISSAL OF CASE**

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PROVIDER REIMBURSEMENT REVIEW BOARD

6660 Security Boulevard  
Baltimore, Maryland 21207

Jan. 10, 1995

REFER TO 95-0006G  
CERTIFIED MAIL

Location Professional Bldg  
Room 104

Diana L. Gustin, Esq.  
London & Amburn  
1716 Clinch Avenue  
Knoxville, TN 37916

Dear Ms. Gustin:

RE: Your Home Visiting Nurse Services, Inc., Denial of  
the Reopening Group Appeal, Provider Nos. 44-  
H003, 44-7100, 44-7234, 44-7304, FYE 12/31/89,  
PRRB Case No. 95-0006G

The Provider Reimbursement Review Board (Board) has  
reviewed the documentation submitted in the above cap-  
tioned case. The decision of the Board is set forth below.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R.  
§§ 405.1835 and .1841, a provider has a right to hearing  
before the Board with respect to costs claimed on a timely  
filed cost report if it is dissatisfied with the final deter-  
mination of the Intermediary, the threshold amount of  
\$50,000 required for Board jurisdiction over a group  
appeal has been met, and the request for hearing is filed  
within 180 days of the date of the final determination.

In this case, the Provider filed an appeal within 180 days  
from the date of the refusal of the Intermediary to reopen  
the cost report; but more than 180 days after the Notice of

Program Reimbursement (NPR) had been issued. The Board finds that it does not have jurisdiction over the Intermediary's refusal to reopen the cost report. The Board holds that 42 C.F.R. § 405.1885(c) governs the review of a denial to reopen a cost report. Section 405.1885(c) states that jurisdiction for reopening a determination rests exclusively with the administrative body that rendered the last determination. Since the Intermediary was the administrative body that rendered the last determination, it is the Intermediary's decision whether or not to reopen the cost report.

Consequently, the Board finds that it does not have jurisdiction over this appeal and hereby dismisses this case. This determination is subject to the provisions of 42 U.S.C. § 1395(f) and 42 C.F.R. § 405.1875 and .1877.

FOR THE BOARD:

/s/ Charles E. Tyler  
Charles E. Tyler  
Board Member

Enclosures: 42 U.S.C. § 1395(f), 42 C.F.R. §§ 405.1875 and .1877

cc: Bessie T. Wheeler, BC/BS of South Carolina  
Wilson Leong, BCBSA

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**APPENDIX B**  
**INTERMEDIARY REFUSAL TO REOPEN**

**Medicare**

Audit and Reimbursement  
Post Office Box 100190  
Columbia, South Carolina 29202

April 21, 1994

Ms. Diana L. Gustin  
London & Amburn, P.C.  
1716 Clinch Avenue  
Knoxville, Tennessee 37916

Re: Your Home Visiting Nurse Service, Inc.  
Provider No: 4407100, 44-7300, 44-7234, 44-7304  
FYE: December 31, 1989

Dear Ms. Gustin:

I am writing in response to your letter of March 28, 1994, which was addressed to Bruce Hughes. In this letter, you requested a reopening of the 1989 cost reports of Your Home Visiting Nurse Service, Inc., to increase the amount of owners' compensation. The compensation contained on the settled cost reports is the amount that was initially claimed when the cost reports were filed.

A request for reopening can be granted for several reasons. These reasons, as stated in Section 2931.2 of HCFA Publication 15-1, are:

new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions.

Your request for reopening is denied. The manner in which the home office cost statement was filed was not

inconsistent with the law, regulations and rulings or general instructions. A clear and obvious error was not made when these cost reports were filed. And, new and material evidence has not been presented to establish that the compensation claimed was inappropriate.

If you have any questions, you may contact me at (803) 788-0222, extension 1252.

Sincerely,

/s/ Jim Peebles  
Jim Peebles  
Audit Manager  
Medicare Audit and Reimbursement

cc: Bruce Hughes, Medicare Administration  
Sharon Roberts, Medicare Audit and Reimbursement  
Bessie Wheeler, Medicare Audit and Reimbursement  
Pat Anderson, Medicare Audit and Reimbursement

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**APPENDIX C**  
**COURT OF APPEALS JUDGMENT**  
**ISSUED AS MANDATE**

App. 38

**UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT**

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No: 96-5525

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YOUR HOME VISITING NURSE SERVICES, INC.,  
Plaintiff-Appellant,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,  
Defendant-Appellee.

Before: Lively, Merritt, and Suhrheinrich, Circuit Judges.

**JUDGMENT**

(Filed Dec. 22, 1997)

ON APPEAL from the United States District Court  
for the Eastern District of Tennessee at Knoxville.

THIS CAUSE was heard on the record from the dis-  
trict court and was argued by counsel.

IN CONSIDERATION WHEREOF, it is ORDERED  
that the judgment of the district court is AFFIRMED.

**ENTERED BY ORDER OF THE COURT**

/s/ Leonard Green  
Leonard Green, Clerk

App. 39

Issued as Mandate: February 20, 1998      A True Copy.

COSTS: NONE

Attest:

Filing Fee .....\$    /s/ Patricia J. Elder

Printing .....\$      Deputy Clerk

Total .....\$

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**APPENDIX D**  
**STATUTES, CONSTITUTIONAL**  
**PROVISIONS, AND REGULATIONS**

## **I. STATUTORY PROVISIONS**

### **5 U.S.C. § 504 (West 1996) – Equal Access to Justice Act: Costs and Fees of Parties**

(a)(1) An agency that conducts an adversary adjudication shall award, to a prevailing party other than the United States, fees and other expenses incurred by that party in connection with that proceeding, unless the adjudicative officer of the agency finds that the position of the agency was substantially justified or that special circumstances make an award unjust. Whether or not the position of the agency was substantially justified shall be determined on the basis of the administrative record, as a whole, which is made in the adversary adjudication for which fees and other expenses are sought

### **5 U.S.C. § 706 (West 1996) – Administrative Procedure Act: Scope of Review**

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall –

- 1) compel agency action unlawfully withheld or unreasonably delayed; and
- 2) hold unlawful and set aside agency action, findings, and conclusions found to be –
  - A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
  - B) contrary to constitutional right, power, privilege, or immunity;

- C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
- D) without observance of procedure required by law;
- E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
- F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

**28 U.S.C. § 1254 (West 1993) Courts of appeals; certiorari; certified questions**

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

- (1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;
- (2) By certification at any time by a court of appeals of any question of law in any civil or criminal case as to which instructions are desired, and upon such certification the Supreme Court may give binding instructions or require the entire record to be sent up for decision of the entire matter in controversy.

**28 U.S.C. § 1331 (West 1996) – Federal Question Jurisdiction**

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

**28 U.S.C. § 1361 (West 1996) – Mandamus**

The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

**28 U.S.C. § 2412 (West 1996) – Equal Access to Justice Act**

(b) Unless expressly prohibited by statute, a court may award reasonable fees and expenses of attorneys, in addition to the costs which may be awarded pursuant to subsection (a), to the prevailing party in any civil action brought by or against the United States or any agency or any official of the United States acting in his or her official capacity in any court having jurisdiction of such action. The United States shall be liable for such fees and expenses to the same extent that any other party would be liable under the common law or under the terms of any statute which specifically provides for such an award.

**42 U.S.C. § 405(h) (West Supp. 1997) – Commissioner's Decision Binding**

(h) The findings and decisions of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such a hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, United States Code, to recover on any claim arising under this title.

**42 U.S.C. § 1395x(v)(1)(A) (West Supp. 1997) – Reasonable Cost**

(v)(1)(A) The reasonable cost of any services shall be the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations

(which have developed such principles) in computing the amount of payment, to be made by persons other than recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

**42 U.S.C. § 1395oo (West Supp. 1996) – Provider Reimbursement Review Board: Jurisdiction**

a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such subsection may obtain a hearing with respect to such payment by the Board, if –

(1) such provider –

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) or section 1886,

(B) has not received such final determination from such intermediary of a timely basis after filing such report where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is \$10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the \$10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, \$50,000 or more.

c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

d) A decision by the Board shall be based upon the record made at such hearing, which shall include the

evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provision of subsections (d) and (e) of section 205 with respect to subpoenas shall apply to the Board to the same extent as they apply to the Secretary with respect to title II.

f) (1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmation, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmation, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a

question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determinations in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to other provisions in section 205. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing

under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund for the month in which the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this Act.

g)(1) The finding of a fiscal intermediary that no payment may be made under this title for any expenses incurred for items and services furnished to an individual because such items or services are listed in section 1862 shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(2) The determinations and other decisions described in section 1886(d)(7) shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. Two of such members

shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5, United States Code. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

i) The Board is authorized to engage in such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

j) In this section, the term "provider of services" includes a rural health clinic and a Federally qualified health center.

## II. CONSTITUTIONAL PROVISIONS

### U.S. Const. amend. V.

No person shall be held to answer for a capital or otherwise infamous crime, unless on a presentment or indictment of a grand jury, except in cases arising in the land or naval forces, or in the militia, when in actual service in time of war or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb, nor shall be compelled in any criminal case to

be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

### III. REGULATIONS

#### 42 C.F.R. § 405.1885 (1997) – Reopening a determination or decision

a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, or by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officers or panel of hearing officers, Board, Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or, where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

b) A determination or a hearing decision rendered by the intermediary shall be reopened and revised by the intermediary if, within the aforementioned 3-year period, the Health Care Financing Administration notifies the intermediary that such determination or decision is

inconsistent with the applicable law, regulations, or general instructions issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the intermediary.

c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault or any party to the determination or decision.

e) Paragraphs (a) and (b) of this section apply to determinations on cost reporting periods ending on or after December 31, 1971. (See § 405.1801(c)). However, the 3-year period described shall also apply to determinations with respect to cost reporting periods ending prior to December 31, 1971, but only if the reopening action was undertaken after May 27, 1972 (the effective date of the regulations which, prior to the publication of the Subpart R, governed the reopening of such determinations).

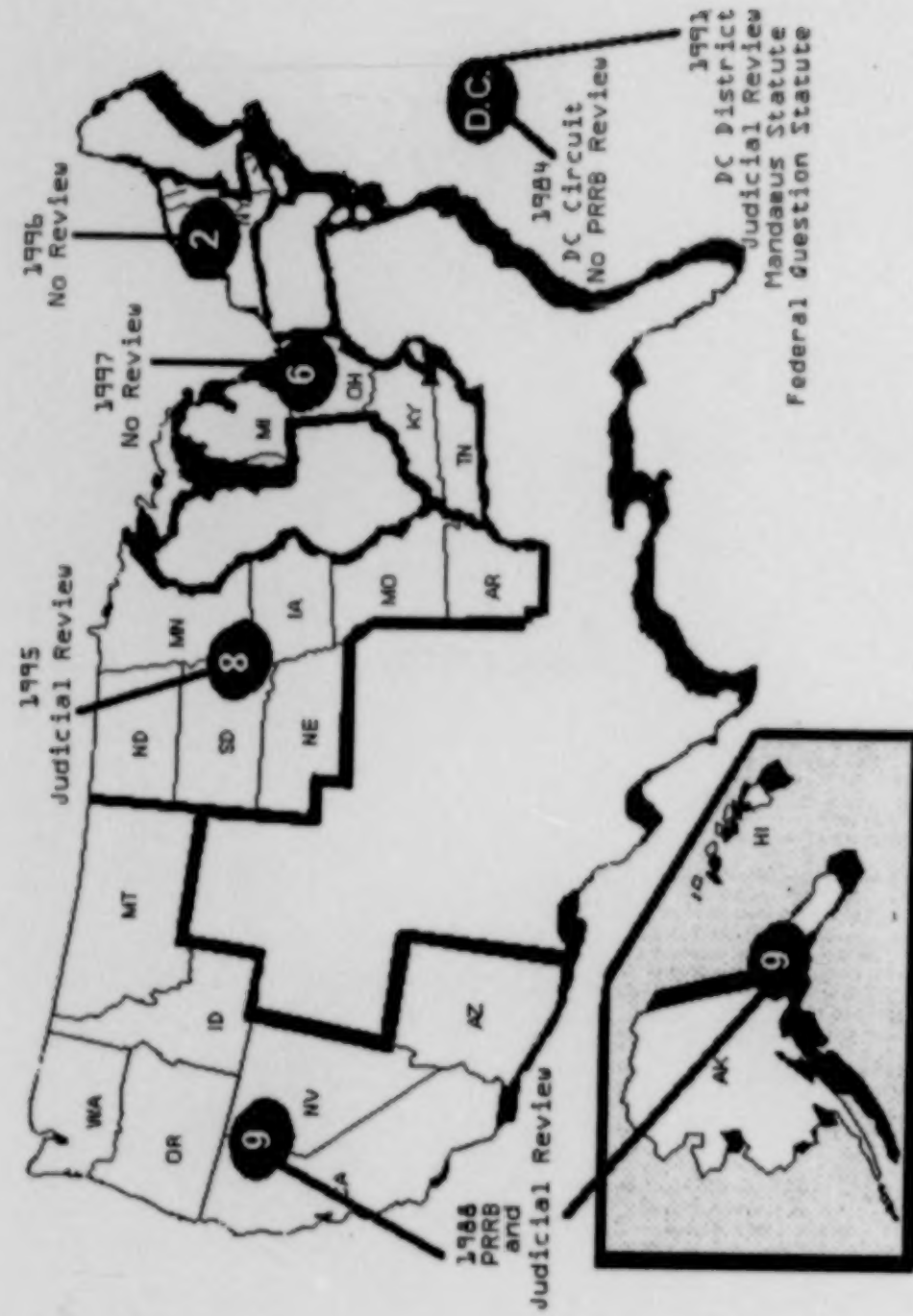
#### 42 C.F.R. § 421.5(b) (1997) – Intermediaries and Carriers: General Provisions

(b) Indemnification of intermediaries and carriers. Intermediaries and carriers act on behalf of HCFA in carrying out certain administrative responsibilities that the law imposes. Accordingly, their agreements and contracts

contain clauses providing for indemnification with respect to actions taken on behalf of HCFA and HCFA is the real party of interest in any litigation involving the administration of the program.

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**APPENDIX E**  
**MAP OF JURISDICTIONS**





**APPENDIX E**  
**SETTLEMENT**

FILE COPY

DIANA L. GUSTIN  
ATTORNEY AT LAW

FIRST TENNESSEE PLAZA, SUITE 2001

• 800 SOUTH GAY STREET

• KNOXVILLE, TENNESSEE 37929

TELEPHONE (423) 523-5545 • TELECOPIER (423) 523-4738

February 19, 1997

Ms. Patricia J. Elder, Case Manager  
United States Court of Appeals  
for the Sixth Circuit

100 East Fifth Street, Rm. 532  
Potter Stewart U.S. Courthouse  
Cincinnati, Ohio 45202-3988

RE: Your Home Visiting Nurse Service, Inc. v.  
Sect. Health & Human Services and  
Health Care Finance Administration  
Case No. 96-5525  
Dist. Court No. 95-CV-276

Dear Ms. Elder:

Enclosed please find a copy of an Administrative Resolution which covered several different years of Owners' Compensation to the Plaintiff/Appellant on the above captioned matter. The Administrative Resolution was entered into on October 4, 1996. The Plaintiff/Appellant filed its reply brief on June 11, 1996. I would like to include the Administrative Resolution as a late filed exhibit to the Plaintiff/Appellant's reply brief. Please let me know the procedure I should follow to accomplish this filing.

App. 56

Please contact me to advise.

Sincerely,

/s/ Diana L. Gustin  
Diana L. Gustin

DLG/bsl

Enclosure

cc: Ms. Betty Leake, YHVNS  
Mr. Howard Lewis, DHHS

---

App. 57

**BlueCross BlueShield  
Association**

An Association of  
Independent Blue Cross  
and Blue Shield Plans

676 North St. Clair Street  
Chicago, Illinois 60611  
Telephone 312.440.6023  
Fax 312.440.5950

Bernard M. Talbert  
Associate General Counsel

**Via Facsimile**

October 4, 1996

Mr. Gene Barnett  
Medicare Audit & Reimbursement  
Blue Cross and Blue Shield of  
South Carolina  
P.O. Box 199190  
Columbia, SC 29202

**Re: Your Home Visiting Nurse Service  
PRRB Case No. 89-0277G and subsequent years**

Dear Gene:

Thanks for the proposed Administrative Resolution for Your Home Visiting Nurse Service (YHVNS) as well as the October 4, 1996 letter to Diane Gustin. I thought you did a great job of coming up with a practical approach to a difficult case. Please accept this letter as BCBSA's formal approval.

App. 58

If you have any questions, please call.

Very truly yours,

/s/ Bernie Talbert  
Bernard M. Talbert

cc: Diana Gustin, Esq. (*Via Fax*)

---

App. 59

[LOGO]

Medicare

Palmetto Government Benefits Administrators

*Audit and Reimbursement*

Post Office Box 100190

Columbia, South Carolina 29202-3190

October 4, 1996

Diana Gustin

Attorney At Law

First Tennessee Plaza, Suite 2001

800 South Gay Street

Knoxville, Tennessee 37929

Re: Your Home Visiting Nursing Services

Compensation Appeal

Provider Number: Various

FYE: 12/31/87, 12/31/90, 12/31/91,  
12/31/92, 12/31/93 and 12/31/94

PRRB Case Numbers: Various

This letter is to confirm the resolution of the PRRB cases for the above listed FYEs. The parties have agreed that the amounts listed on the attachments to this letter titled "YHVNS' Owners Compensation - Proposed Administrative Resolution" and "YHVNS' Owners' Compensation Proposed, Pension Expense" will be allowed. Additionally, the Intermediary agrees that any interest applicable to the overpayment involved with these adjustments will be refunded pursuant to 42 CFR 405.376 and Provider Reimbursement Manual Section 2219.5(B). Further, the Intermediary agrees to expedite the reopening of the applicable cost reports.

This agreement will need to be affirmed by the Blue Cross and Blue Shield Association. You should receive this by

Monday, October 7, 1996. If you have any questions or if you do not receive the BCBSA's official approval, please give me a call at home at (803) 787-6287 or at Palmetto GBA at (803) 788-0222, extension 26227.

Sincerely

/s/ Gene Barnett  
 Gene J. Barnett, Esq.  
 Provider Appeals Specialist  
 Medicare Audit and Reimbursement

cc: Bernard Talbert, Esq., BCBSA

YHVNS' OWNERS' COMPENSATION - PROPOSED  
 ADMINISTRATIVE RESOLUTION

Betty Leake

	Paid	Allowed	Proposed Allowable Amount	Reopening Adjustment
1994	154,407	130,051	141,000	10,949*
1993	165,152	122,114	132,000	9,886*
1992	163,401	114,661	124,000	9,339*
1991	141,065	107,663	117,000	9,337*
1990	115,568	101,092	109,000	7,908*
1989	NA			
1988	NA			
1987	92,139	71,331	86,000	14,669

Richard Leake

	Paid	Allowed	Proposed Allowable Amount	Reopening Adjustment
1994	135,246	96,913	99,000	2,087*
1993	130,675	90,998	93,000	2,002*
1992	123,463	85,444	87,000	1,556*
1991	108,729	56,893	82,000	25,107*
1990	79,468	43,804	77,000	33,196
1989	N/A			
1988	N/A			
1987	70,324	32,884	60,000	27,116

Rick Leake

	Paid	Allowed	Proposed Allowable Amount	Reopening Adjustment
1994	59,556	44,150	51,000	6,850*
1993	55,895	41,455	48,000	6,545*
1992	45,609	38,925	45,000	6,075*
1991	36,943	36,943	42,000	0

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1990	39,216	34,318	39,216	4,898
1989	N/A			
1988	N/A			
1987	16,009	14,663	16,009	1,346

(worked only part of year)

\*An additional amount will be allowed to partially reverse the adjustment made to pension expense based on salary. Will compute after salary is approved. Generally an additional 15% will be added, but for some years the entire allowable pension expense was not incurred.

Pension Expense

Betty Leake

	Comp. Adj. (See other Attachment)	Pension Reopening Adjustment
1994	No pension adjustment was made	
1993		955
1992	9,339	1,346
1991	9,337	1,401
1990	7,908	1,186

Richard Leake

1994	No pension adjustment was made	
1993	2,002	300
1992	1,556	224
1991	25,107	3,766
1990	33,196	4,979

Rick Leake

1994	No pension adjustment was made	
1993	6,545	982
1992	6,075	875
		<u>16,015</u>

2

Supreme Court, U. S.

FILED

MAY 11 1998

No. 97-1489

CLERK

**In the Supreme Court of the United States**

OCTOBER TERM, 1997

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YOUR HOME VISITING NURSE SERVICES, INC.,  
PETITIONER

v.

DONNA E. SHALALA, SECRETARY OF  
HEALTH AND HUMAN SERVICES

---

ON PETITION FOR A WRIT OF CERTIORARI TO  
THE UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT

---

**BRIEF FOR THE RESPONDENT**

---

SETH P. WAXMAN

*Solicitor General*

*Counsel of Record*

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*Assistant Attorney General*

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*Department of Justice*

*Washington, D.C. 20530-0001*

*(202) 514-2217*

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23 PP

### QUESTIONS PRESENTED

1. Whether the denial of a Medicare provider's request to reopen an annual reimbursement determination under Part A of the Medicare program is subject to review under 42 U.S.C. 139500, and if not, whether the denial is subject to judicial review under 28 U.S.C. 1331 or 28 U.S.C. 1361.

2. Whether the government's position is "substantially justified" under the Equal Access to Justice Act, 5 U.S.C. 504 and 28 U.S.C. 2412.

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## In the Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-1489

YOUR HOME VISITING NURSE SERVICES, INC.,  
PETITIONER

*v.*

DONNA E. SHALALA, SECRETARY OF  
HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO  
THE UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT

### BRIEF FOR THE RESPONDENT

#### OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-15) is reported at 132 F.3d 1135. The opinion of the district court (Pet. App. 17-33) is unreported. The decision of the Provider Reimbursement Review Board (Pet. App. 34-35) is unreported.

#### JURISDICTION

The judgment of the court of appeals (Pet. App. 38-39) was entered on December 22, 1997. The petition for a writ of certiorari was filed on March 11, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

## STATEMENT

1. In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered inpatient hospital and related post-hospital services including certain home health services that are provided to an individual on a visiting basis in the individual's place of residence. 42 U.S.C. 1395x(m).<sup>1</sup> When patient beneficiaries receive covered home health services, the Secretary reimburses the providers of those services under the Medicare Act and the Secretary's implementing regulations. 42 U.S.C. 1395f(b)(1), 1395x(v)(1)(A).

A provider's total allowable Medicare payment is based on a "cost report" that it must prepare after the close of its fiscal year. 42 U.S.C. 1395g; 42 C.F.R. 405.1801(b), 413.24(f). The cost report is filed with a "fiscal intermediary" (usually an insurance company) designated by the Secretary. 42 U.S.C. 1395h. The cost report shows the provider's costs and the percentage of those costs allocated to Medicare services. 42 C.F.R. 413.20(b), 413.24(f). The intermediary analyzes the cost report, audits it if necessary, and issues the provider a written "notice of amount of program reimbursement" (NPR) containing the final determination of the total amount to be paid for Medicare services during the reporting period. 42 C.F.R. 405.1803. See *Regions Hosp. v. Shalala*, 118 S. Ct. 909, 913 (1998).

<sup>1</sup> Part B is a voluntary supplementary insurance program covering physicians' charges and other medical services. 42 U.S.C. 1395k, 1395l, 1395x(s). This case arises under the Part A program.

Congress has specified in the Medicare Act itself a comprehensive scheme for administrative and judicial review of "a final determination [of a fiscal intermediary] as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under [Medicare] for the period covered by [the provider's cost] report." 42 U.S.C. 1395oo(a)(1)(A)(i).<sup>2</sup> A "dissatisfied" provider may obtain a hearing before the Provider Reimbursement Review Board (PRRB) if the amount in controversy equals or exceeds \$10,000 and the provider requests a hearing "within 180 days after notice of the intermediary's determination." 42 U.S.C. 1395oo(a)(1)(A)(i) and (a)(3); 42 C.F.R. 405.1835; see *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 403-404 (1988). The Board has the authority to "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to [the] cost report and to make any other revisions on matters covered by such cost report \* \* \* even though such matters were not considered by the intermediary in making [its] final determination." 42 U.S.C. 1395oo(d). The Board's decision, unless modified by the Secretary, is final, and is subject to judicial review in federal district court if an action is brought within 60 days. 42 U.S.C. 1395oo(f)(1); 42 C.F.R. 405.1877.

By regulation, a determination by the intermediary may be "reopened" within three years (or at any time in the case of fraud) with respect to specific findings

<sup>2</sup> Congress also has established administrative and judicial review procedures for individuals who are denied Medicare benefits under Part A or B of the Medicare program. See 42 U.S.C. 1395ff (incorporating procedures under 42 U.S.C. 405(b) and (g)).

at issue in the intermediary's determination, by motion of either the intermediary or the provider affected by the intermediary's determination. 42 C.F.R. 405.1885(a) and (d); see *Regions Hosp.*, 118 S. Ct. at 913.<sup>3</sup> The Secretary's reopening regulation also provides that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R. 405.1885(c). The Secretary's Provider Reimbursement Manual (PRM) further explains that "[a] provider has no right to a hearing on a finding by an intermediary \* \* \* that a reopening \* \* \* of a determination \* \* \* is not warranted." PRM § 2932.1. The PRM similarly states that "[a] refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 C.F.R. § 405.1885(c)." PRM § 2926, App. A, ¶ B.4. In the event the intermediary does reopen the prior determination, however, a provider may appeal to the Board any adjustments made by the intermediary in a revised NPR. 42 C.F.R. 405.1889. The Board's decision concerning the revised NPR would then be subject to judicial review under 42 U.S.C. 1395oo(f)(1).

Finally, the second and third sentences of Section 205(h) of Title II of the Social Security Act, made applicable to the Medicare Act by 42 U.S.C. 1395ii, provide:

No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No

<sup>3</sup> The regulation also authorizes the Board and the Secretary to reopen one of their respective decisions. 42 C.F.R. 405.1885(a).

action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. 405(h).

2. Petitioner provides home health care services to Medicare beneficiaries and is reimbursed on a reasonable cost basis. Pet. App. 2; see 42 U.S.C. 1395f(b)(1)(A). For its 1989 fiscal year, petitioner submitted four cost reports for its home health agencies. The reports sought payment for certain compensation to its owners as an allowable cost reimbursable under the Medicare program. See 42 C.F.R. 413.102(a). On March 29, 1991, petitioner's fiscal intermediary issued four NPRs that disallowed a portion of those costs and determined the total amount of program reimbursement due to petitioners. Admin. Rec. 15-33. The NPRs also notified petitioner of its statutory right to seek review of the intermediary's determination before the PRRB within 180 days. *Id.* at 17, 20, 23, 26. Petitioner did not appeal any of the four NPRs to the PRRB within the time period specified by 42 U.S.C. 1395oo(a)(3). Pet. 23; Pet. App. 3.

On March 28, 1994, less than three years from the date of the issuance of the NPRs for petitioner's fiscal year 1989, petitioner requested its intermediary to reopen its final reimbursement determination for 1989 under the Secretary's reopening regulation. Admin. Rec. 12-14. Petitioner claimed that the intermediary improperly disallowed a portion of the owners' compensation costs for which petitioner sought reimbursement, because the intermediary failed to compare petitioner's costs to salary data for officers of home health agency chains. *Ibid.* The

intermediary denied the request for reopening. Pet. App. 36-37. On October 14, 1994, petitioner sought to appeal the intermediary's denial to the PRRB. Admin. Rec. 7-8. On January 10, 1995, the PRRB dismissed petitioner's appeal on the ground that it lacked jurisdiction under 42 C.F.R. 405.1885(c). Pet. App. 34-35. The PRRB concluded that, because "the Intermediary was the administrative body that rendered the last determination [on petitioner's reimbursement], it is the Intermediary's decision whether or not to reopen the cost report." *Id.* at 35.

3. Petitioner filed suit in the United States District Court for the Eastern District of Tennessee requesting that the court order the PRRB to review the intermediary's refusal to reopen its final determination for petitioner's 1989 fiscal year or, in the alternative, that the court order the intermediary to reopen petitioner's NPR to make additional payments for the claimed costs regarding owners' compensation. Compl. 6-7. The district court dismissed petitioner's complaint on the ground that the PRRB does not have jurisdiction under 42 U.S.C. 139500(a) over an intermediary's refusal to reopen a provider's NPR. Pet. App. 16-33. The court reasoned that "the Secretary's determination as reflected in the Medicare regulations and Provider Reimbursement Manual that denials of reopening requests are unreviewable is a reasonable interpretation of the Medicare statute." *Id.* at 26. The court also rejected petitioner's alternative claim that the court could review the intermediary's refusal to reopen through the exercise of either general federal question jurisdiction under 28 U.S.C. 1331 or mandamus jurisdiction under 28 U.S.C. 1361. Pet. App. 30-32.

4. The court of appeals affirmed. Pet. App. 1-15. It concluded that the language in 42 U.S.C. 139500(a) that identifies what triggers a right of review by the Board—"a final determination \* \* \* of the intermediary \* \* \* as to the amount of total program reimbursement due the provider"—does not clearly encompass an intermediary's denial of a request to reopen a prior determination, and that the Secretary's reopening regulation and interpretive guidelines reflect the reasonable interpretation that the statute does not grant the PRRB jurisdiction over an intermediary's denial of a request to reopen. Pet. App. 4-7. The court also found its conclusion "bolstered" by *Califano v. Sanders*, 430 U.S. 99, 108 (1977), in which the Court concluded that the Social Security Act, 42 U.S.C. 405(g), does not authorize federal courts to review alleged abuses in agency discretion in refusing to reopen Social Security disability claims. Pet. App. 7-8.

The court of appeals further concluded that 42 U.S.C. 405(h) precludes a district court from exercising its general federal question jurisdiction under 28 U.S.C. 1331 to review an intermediary's denial of a request to reopen, because petitioner's claims for additional reimbursement arise under the Medicare Act. Pet. App. 11-12. Finally, reasoning that a fiscal intermediary's "decision not to reopen [i]s discretionary," the court of appeals rejected petitioner's contention that the intermediary's denial of reopening is reviewable pursuant to the district court's mandamus jurisdiction under 28 U.S.C. 1361. Pet. App. 14-15.

#### ARGUMENT

The court of appeals correctly concluded that neither the Provider Reimbursement Review Board

nor the federal courts have jurisdiction to review the merits of a fiscal intermediary's denial of a provider's request to reopen a final Medicare reimbursement determination. We nevertheless agree with petitioner that the Court should grant certiorari in this case. The courts of appeals are divided on the question whether the Secretary reasonably construed 42 U.S.C. 139500(a) not to require the PRRB to review an intermediary's denial of a request to reopen, and the question whether such a denial is reviewable is of considerable importance to the administration of the Medicare program.

1. a. The court of appeals properly applied the two-step analysis of this Court's decision in *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842, 843 (1984), in sustaining the Secretary's interpretation of the relevant provision of the Medicare Act. See also *Regions Hosp.*, 118 S. Ct. at 915; *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994); *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 414 (1993). Section 139500(a)(1)(A)(i) authorizes the Board to review a fiscal intermediary's "final determination \* \* \* as to the amount of total program reimbursement due the provider \* \* \* for the period covered by [the provider's cost] report." That language plainly refers to the fiscal intermediary's issuance of the NPR reflecting the total reimbursement due the provider for that fiscal year. It does not readily encompass, however, a denial by the intermediary of a request to alter a prior determination as to whether particular cost items are reimbursable. As the court below explained:

[T]he plain meaning of [Section] 139500(a) does not compel a holding that a reopening denial is a "final

determination" of the amount of total program reimbursement. To the contrary, \* \* \* the statute may be construed permissibly as stating that a reopening denial is a refusal to revisit the final determination. . . . [W]hile . . . a decision not to reopen is in some sense "final," it does not, in and of itself, establish an amount of total program reimbursement [as required by the statute].

Pet. App. 6-7 (quoting *Good Samaritan Hosp. Reg. Med. Ctr. v. Shalala*, 85 F.3d 1057, 1061-1062 (2d Cir. 1996), quoting *Good Samaritan Hosp. Reg. Med. Ctr. v. Shalala*, 894 F. Supp. 683, 690 (S.D.N.Y. 1995)).

Moreover, reopening is not mandated by Act but is instead authorized solely by the Secretary's reopening regulation. *HCA Health Servs. of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 618-619 (D.C. Cir. 1994) (Secretary promulgated reopening rules under her general rulemaking authority under 42 U.S.C. 1302 and 1395hh); see also *Regions Hosp.*, 118 S. Ct. at 913 ("By regulation, the Secretary may reopen, within three years," citing 42 C.F.R. 405.1885(a)). Thus, although Congress intended in Section 139500 to authorize administrative and judicial review of the intermediary's annual determination as to the total amount of program reimbursement, the Act is silent with respect to whether, and to what extent, the denial of a request to reopen an otherwise final reimbursement determination would be permitted or subject to review.

"In light of this statutory ambiguity" (Pet. App. 7), the Secretary permissibly interpreted Section 139500(a) and her regulations not to require administrative and judicial review of an intermediary's denial of a request to reopen. A contrary interpretation

would subject the PRRB to repeated appeals of reopening denials and "frustrat[e] the congressional purpose to impose a 180-day limitation upon [PRRB] review of a fiscal intermediary's final determination on an initial cost report." Pet. App. 8.

This Court reached a similar conclusion in *Califano v. Sanders*, *supra*, when it held that 42 U.S.C. 405(g) did not authorize judicial review of a denial of a motion to reopen a decision of a claim for Social Security benefits. The Court observed that "the opportunity to reopen final decisions and any hearing convened to determine the propriety of such action are afforded by the Secretary's regulations and not by the Social Security Act." 430 U.S. at 108. "Moreover," the Court reasoned, "an interpretation that would allow a claimant judicial review simply by filing—and being denied—a petition to reopen his claim would frustrate the congressional purpose, plainly evidenced in [42 U.S.C. 405(g)], to impose a 60-day limitation upon judicial review of the Secretary's final decision on the initial claim for benefits." *Ibid*. Similarly, in construing Section 1395oo(a) not to provide for review of a denial of request to reopen under the Medicare program, the Secretary reasonably adopted a "policy \* \* \* obviously designed to forestall repetitive or belated litigation of stale eligibility claims." 430 U.S. at 108.

b. The court of appeals also correctly concluded that the district court lacked jurisdiction under 28 U.S.C. 1331 to review the intermediary's refusal to reopen its otherwise final determination. Section 405(h), which is expressly incorporated into the Medicare Act by 42 U.S.C. 1395ii, prohibits federal courts from exercising jurisdiction under 28 U.S.C. 1331 to hear "all claim[s] arising under' the Medicare

Act." *Heckler v. Ringer*, 466 U.S. 602, 614-615 (1984) (quoting 42 U.S.C. 405(h)); see also *Califano v. Sanders*, 430 U.S. at 103 n.3; *Weinberger v. Salfi*, 422 U.S. 749, 760-761 (1975). Because petitioner seeks a review of the intermediary's refusal to reopen petitioner's NPR for fiscal year 1989 or, alternatively, an increase in its reimbursement for owners' compensation costs, petitioner's claims plainly arise under the Medicare Act and may not be pursued under 28 U.S.C. 1331.

In arguing to the contrary, petitioner principally relies (Pet. 9-22) on this Court's decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). In that case, the Court concluded that a federal court had jurisdiction under 28 U.S.C. 1331 to review a challenge to the validity of a Medicare regulation governing payments to physicians under Part B of the Medicare program. At that time, Section 1395ff provided for a hearing and judicial review of challenges to payments made under Part A but not Part B of the program. See 476 U.S. at 674 n.5 (quoting 42 U.S.C. 1395ff (1982)). The Court concluded that neither 42 U.S.C. 405(h) nor 42 U.S.C. 1395ff(b) (as it then existed) precluded "challenges mounted against the *method* by which [the] amounts [of Part B benefits] are to be determined rather than the *determinations* themselves." 476 U.S. at 675.

Contrary to the situation at issue in *Michigan Academy*, petitioner does not challenge a methodology for computing Medicare payments under Part B that would otherwise be immune from judicial review. Instead, Section 1395oo explicitly grants providers a right to challenge an intermediary's determination under Part A as to the amount of Medicare reimbursement owed to the provider in a given cost year.

Like the claimant in *Califano*, petitioner had such review available to it, but failed to exercise its rights under the Act. Indeed, after Congress in October 1986 amended Section 1395ff to provide for administrative and judicial review of challenges to payments made under Part B of the Medicare program, Pub. L. No. 99-509, § 9341(a)(1)(B), 100 Stat. 2037, lower courts have held that federal courts lack jurisdiction under 28 U.S.C. 1331 to review any claim arising under Part B of the program, including the type of methodology disputes at issue in *Michigan Academy*. See *Farkas v. Blue Cross and Blue Shield of Mich.*, 24 F.3d 853, 859-861 (6th Cir. 1994); *Abbey v. Sullivan*, 978 F.2d 37, 41-44 (2d Cir. 1992); *National Kidney Patients Ass'n v. Sullivan*, 958 F.2d 1127, 1130-1134 (D.C. Cir. 1992), cert. denied, 506 U.S. 1049 (1993). Accordingly, this Court's decision in *Michigan Academy* does not support petitioner's position in this case.

c. Finally, the court of appeals correctly concluded that a decision whether to reopen a final determination is not subject to a federal court's mandamus jurisdiction under 28 U.S.C. 1361. Pet. App. 13-14. Although this Court has declined to decide whether Section 405(h) precludes federal mandamus jurisdiction under 28 U.S.C. 1361, the Court has concluded that such jurisdiction is appropriate under the Medicare program "only if the defendant owes [the plaintiff] a clear nondiscretionary duty." *Heckler v. Ringer*, 466 U.S. at 616. That requirement is not met in this case. On its face, the Secretary's reopening regulation vests the intermediary—the "administrative body that rendered the last determination"—with "exclusive[]" jurisdiction to decide whether to reopen its own prior determination. 42 C.F.R. 405.1885(c). Moreover, the regulation employs discretionary lan-

guage when it provides that "[a] determination of an intermediary \* \* \* *may* be reopened \* \* \* by such intermediary \* \* \* on motion of the provider affected by such determination." 42 C.F.R. 405.1885(a) (emphasis added). Accordingly, the court of appeals properly concluded that federal courts lack mandamus jurisdiction over a denial of a request to reopen.

2. a. Although the decision of the court of appeals is correct, we agree with petitioner that the Court should grant certiorari in this case. In addition to the Sixth Circuit in this case, the Second Circuit held in *Good Samaritan Hospital Regional Medical Center v. Shalala*, 85 F.3d 1057, 1060-1062 (1996), that the Secretary reasonably construed 42 U.S.C. 1395oo(a) and 42 C.F.R. 405.1885 to preclude review of an intermediary's denial of a request to reopen a prior determination. Similarly, the D.C. Circuit has stated that reopening denials under 42 C.F.R. 405.1885 are unreviewable. See *Athens Community Hosp. v. Schweiker*, 743 F.2d 1, 4 n.4, 8 (1984), and *St. Mary of Nazareth Hosp. Ctr. v. Schweiker*, 741 F.2d 1447, 1449 (1984).<sup>4</sup> By contrast, the Ninth Circuit held in *State of Oregon v. Bowen*, 854 F.2d 346, 349 (1988), that

<sup>4</sup> In *HCA Health Services of Oklahoma, Inc.*, *supra*, the D.C. Circuit upheld the Secretary's position that the PRRB's jurisdiction to review the result of a reopening is limited to the specific issues revised in the reopening. 27 F.3d at 619-622. In reaching that conclusion, the D.C. Circuit reasoned that "[t]he language of the Statute itself \* \* \* leaves us in a quandary as to whether a reopening is a 'final determination . . . as to the amount of total program reimbursement due the provider, within the meaning of [Section] 1395oo(a)(1)(A)(i), to which the rights for Board review under subsections 1395oo(a) and (d) should apply." 27 F.3d at 618-619.

"[t]he plain meaning of Section 139500(a) entitles [providers] to Board review" of an intermediary's decision denying a request to reopen. The Ninth Circuit reasoned that the intermediary's denial is a final determination that "directly implicate[s] 'the amount of total program reimbursement due the provider for items and services furnished.'" 854 F.2d at 349 (quoting 42 U.S.C. 139500(a)(1)(A)(i)).<sup>5</sup> Because the Ninth Circuit concluded that the Secretary's construction of the Act fails under the first-step of the *Chevron* analysis, the decision in *State of Oregon* directly conflicts with the instant decision and the decision of the Second Circuit in *Good Samaritan Regional Hospital Medical Center*.<sup>6</sup>

<sup>5</sup> The Ninth Circuit also reasoned that the Secretary's reopening regulation was mandated by 42 U.S.C. 1395x(v)(1)(A)(ii), which authorizes the Secretary to issue regulations that "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." See 854 F.2d at 349. The Ninth Circuit subsequently concluded, however, that its construction of Section 1395x(v)(1)(A)(ii) in *State of Oregon* has been "undercut" by this Court's decision in *Good Samaritan Hosp. v. Shalala*, 508 U.S. at 414-420, which held that the Secretary reasonably construed Section 1395x(v)(1)(A)(ii) narrowly to refer only to the year-end book-balancing of monthly estimated payments to providers mandated under 42 U.S.C. 1395g with the final post-audit amounts determined to be reimbursable under the Act and the Secretary's regulations. See *French Hosp. Med. Ctr. v. Shalala*, 89 F.3d 1411, 1418 n.8 (9th Cir. 1996).

<sup>6</sup> Contrary to petitioner's assertion (Pet. 6), the Eighth Circuit's decision in *Hennepin County Medical Center v. Shalala*, 81 F.3d 743 (1996), does not bear on the question

Although there is no conflict among the courts of appeals over the question whether federal courts may review a denial of reopening under 28 U.S.C. 1331 or 1361, at least one district court has indicated that such review is authorized. *Memorial Hosp. v. Sullivan*, 779 F. Supp. 1410, 1412 (D.D.C. 1991). Moreover, the court of appeals in this case decided those issues and, therefore, we believe it would be appropriate for the Court to resolve those questions in connection with its resolution of whether the Secretary reasonably interpreted Section 139500(a) not to require review of an intermediary's decision not to reopen an otherwise final determination. Only by doing so could the Court assure a comprehensive resolution of the availability of judicial review.<sup>7</sup>

b. The reviewability of denials of requests to reopen presents an important and recurring issue in the administration of the already overburdened Medicare program.<sup>8</sup> Currently, approximately 38,000 providers

presented. That case involved an intermediary's decision to reopen a final determination. See 81 F.3d at 746.

<sup>7</sup> Neither court below addressed petitioner's contention (Pet. i) that 5 U.S.C. 706 independently grants subject matter jurisdiction over refusals to reopen. The Court in *Califano v. Sanders*, 430 U.S. at 107, however, held that the Administrative Procedure Act "does not afford an implied grant of subject-matter jurisdiction permitting federal judicial review of agency action." Petitioner's further argument (Pet. i, 21, 24-25) that denying judicial review of denials of reopening would violate its due process rights was not raised below. We therefore do not believe that contention should be considered by the Court. See, e.g. *Youakim v. Miller*, 425 U.S. 231, 234 (1976) (per curiam); *Auer v. Robbins*, 117 S. Ct. 905, 912 (1997); *Citizens Bank of Maryland v. Strumpf*, 516 U.S. 16, 21 n.\* (1995).

<sup>8</sup> We have been informed by the Health Care Financing Administration in the Department of Health and Human Ser-

nationwide (and 5,400 in the Ninth Circuit, where *State of Oregon* controls) receive annual NPRs reflecting an intermediary's determination as to the total amount of Medicare reimbursement due the provider. Each of those NPRs relates to thousands of reimbursement determinations that may be subject to a subsequent request by the provider to reopen under 42 C.F.R. 405.1885.<sup>9</sup> The existence of a right to appeal the denial of a request to reopen any of those thousands of determinations should not depend on the fortuity of the State in which the provider resides. Thus, this Court's resolution of the reviewability issue is warranted.

3. Petitioner also requests (Pet. 22-25) that this Court grant certiorari to decide whether the Secretary's position in this case is "substantially justified" under the Equal Access to Justice Act (EAJA), 5 U.S.C. 504 and 28 U.S.C. 2412. There is no basis for review of that issue. Petitioner has not filed a fee application in this case and, because the Secretary prevailed below, neither the district court nor the court of appeals had occasion to address the question whether the Secretary's position should be regarded as substantially justified if petitioner had prevailed. Even were the Court to resolve the merits of this case in petitioner's favor, the fact-bound question of

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vices that, at the present time, the PRRB has a backlog of 10,000 cases.

<sup>9</sup> The Secretary estimates that, at any given time, the PRRB has pending before it approximately 20 appeals of reopening denials by providers located in the Ninth Circuit. Moreover, providers in other circuits that have not resolved the issue continue to challenge denials of reopenings. See, e.g., *St. Vincent Health Ctr. v. Shalala*, 937 F. Supp. 496 (W.D. Pa. 1995), *aff'd*, 96 F.3d 1434 (3d Cir. 1996) (Table).

whether petitioner is entitled to any EAJA fees is more appropriately addressed by the district court in the first instance. See *Pierce v. Underwood*, 487 U.S. 552, 560 (1988).

### CONCLUSION

The petition for a writ of certiorari should be granted, limited to the question whether the denial of a Medicare provider's request to reopen an annual reimbursement determination under the Medicare program is subject to review under 42 U.S.C. 1395oo, 28 U.S.C. 1331, or 28 U.S.C. 1361.

Respectfully submitted.

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**No. 97-1489**

**OFFICE OF THE CLERK  
SUPREME COURT, U.S.**

**In The  
Supreme Court of the United States  
October Term, 1997**

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**YOUR HOME VISITING NURSE SERVICES, INC.,**  
*Petitioner,*

**v.**

**SECRETARY OF HHS,**  
*Respondent.*

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**On Petition For Writ Of Certiorari  
To The United States Court Of Appeals  
For The Sixth Circuit**

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**REPLY BRIEF FOR THE PETITIONER**

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## PETITIONER'S REPLY TO RESPONDENT'S BRIEF

This reply brief is submitted in accordance with United States Supreme Court Rule 15.6 which allows petitioner to address new arguments first addressed in respondent's brief. Accordingly, there are five matters which petitioner will address herein: mandamus jurisdiction, statistics regarding the pending cases at the Provider Reimbursement Review Board, the *Regions Hosp. v. Shalala*, 118 S. Ct. 909 (1998) decision, due process arguments and the right to attorneys fees under the Equal Access to Justice.

### (a) Mandamus Jurisdiction, 28 U.S.C. 1361

The Respondent's brief at page 13 noted that this Court has declined to decide whether Section 405(h) precludes federal mandamus jurisdiction under 28 U.S.C. 1361 but also recognized that the Court has concluded that mandamus jurisdiction is appropriate under the Medicare program if the defendant owes the plaintiff a clear non-discretionary duty. The respondent asserts there is a discretionary decision at issue since the Secretary's reopening regulation vests the intermediary with the exclusive jurisdiction to decide whether to reopen its own prior determination. 42 C.F.R. 405.1885(c). The petitioner however relies upon the non-discretionary duty referenced in the regulation 42 C.F.R. 413.102(b)(2)(i) which requires that owners compensation be " . . . such an amount as would ordinarily be paid for comparable services by comparable institutions." The refusal to reopen the 1989 cost report to correct this error is a violation of a duty which is NOT discretionary. In other

words, the intermediary does not have the discretion to violate this regulation by choosing not to pay the owners of the petitioner/home health agency an amount as would ordinarily be paid for comparable services by comparable institutions, and yet, this is exactly what the intermediary did. The regulation requires that payment to owners be comparable to payment made for comparable services by comparable institutions. Comparing a single home health agency's Administrator's salary to that of a chain operation is not in accordance with this non-discretionary regulation requirement. Therefore, mandamus jurisdiction would be appropriate to provide federal court with authority to order the intermediary to pay the owners in accordance with the regulation because the respondent owes the petitioner a clear non-discretionary duty in this regard.

**(b) Statistics on pending cases at PRRB**

The respondent points out administrative burden which the reviewability of denials of requests to reopen presents as an important and recurring issue for the "already overburdened" Medicare program by citing statistics obtained from the Health Care Financing Administration in the Department of Health and Human Services which allegedly demonstrate PRRB has a backlog of 10,000 cases, that the Secretary estimates that the PRRB has approximately 20 appeals pending, at any given time, on reopening denials by providers located in the Ninth Circuit. (See Respondent's brief at page 16, notes 8 and 9.) While conscious of the administrative burden which

appeal rights create, the petitioner must nevertheless persist in its pursuit of the right to appeal erroneous determinations made by the intermediary. This is true even when the wrongdoing of the intermediary is not discovered until after the initial 180 day deadline to appeal the NPR determination. The three-year time period within which to request a reopening should still allow the provider who discovers the intermediary acted inappropriately to take action against the intermediary. In support of this contention the petitioner would point out that the intermediary is an insurance company which could be guilty of wrongful action. Cases against the insurance companies for wrongful conduct related to Medicare program payments to the insurance companies have been reported. Blue Shield of California was ordered to pay \$1.5 million following a guilty plea on charges that it conspired to obstruct audits conducted over a six-year period in connection with its Medicare Part B contract with HCFA according to a May 1, 1996, Department of Justice press release. (Reported in the Commerce Clearing House Medicare and Medicaid Guide Number 905, May 9, 1996.) Blue Cross and Blue Shield of Florida, Inc., the Medicare Part B carrier for Florida, agreed to pay the federal government \$10 million pursuant to a settlement agreement executed by the parties on August 3, 1993. *U.S. ex rel. Burr v. Blue Cross and Blue Shield of Florida, Inc.*, U.S. District Court for the Middle District of Florida, No. 91-134-Civ-J-16, Aug. 4, 1993. (Reported in the Commerce Clearing House Medicare and Medicaid Guide Number 761, August 18, 1993, and at Paragraph 41,578.) Blue Cross and Blue Shield of Michigan has agreed to pay the government \$27.6 million to

settle allegations that it defrauded the government while acting as the fiscal intermediary in the state of Michigan. *U.S. v. Blue Cross/Blue Shield of Michigan*, U.S.D.C. (Maryland), No. L93-1794, Jan. 10, 1995, settlement agreement executed by the parties. (Reported in the Commerce Clearing House Medicare and Medicaid Guide Number 839, February 2, 1995, and at Paragraph 43,019.) While the administrative burden and a backlog of cases is always a consideration, the right to seek redress for wrongful conduct should take precedence in this situation.

**(c) *Regions Hosp. v. Shalala*, 118 S. Ct. 909 (1998)**

The respondent states that the intermediary analyzes the cost report, audits if necessary, and then issues the written notice of the amount of Medicare program reimbursement to the provider, citing the recent decision of *Regions Hosp. v. Shalala*, 118 S. Ct. 909 (1998). (Respondent's brief at pages 2-3.) It is interesting to note that this case stands for the proposition that additional reopenings beyond the normal three year time frame are acceptable in order to perpetuate the Legislature's overriding purpose in the Medicare scheme: reasonable (not excessive or unwarranted) cost reimbursement. *Id.* at page 905. Therefore, the Secretary's position in *Regions Hospital* creates more administrative burden by allowing reopening and reaudit beyond the three year time frame because this allows the Secretary to recoup reimbursement from providers which may have received too much Medicare money. However, when the provider-petitioner herein seeks reopening within the three year time period because it received too little Medicare reimbursement, the

Secretary fears the administrative burden such corrections might produce. The Secretary is inconsistent. The apparent goal is to recover Medicare reimbursement from providers as opposed to the more appropriate goal of paying the correct amount of reimbursement to providers.

**(d) Due Process, United States Constitution, Amendment V**

The respondent asserts that it does not believe the due process contentions should be considered by the Court citing *Youakim v. Miller*, 425 U.S. 231, 234 (1976). (Respondent's brief at page 16) However, the Court recognized that while it ordinarily does not decide questions not raised or resolved in the lower court the rule is not inflexible. *Id.* at page 234. In *Boynnton v. Virginia*, 364 U.S. 454, 457 (1960) the Court found persuasive reasons why the case should be decided on the Interstate Commerce Act although the petition for certiorari presented only two questions, one of which included the Due Process clause of the Fourteenth Amendment. The Court reasoned that discrimination because of color was the core of the two broad constitutional questions presented, just as it is the core of the Interstate Commerce Act. Under those circumstances, the Court found it appropriate not to reach the constitutional questions but to proceed at once to the statutory issue. While the petitioner believes the Court can and will make its decision in the present case based upon the statutory authorities presented, if that cannot be done then the core argument, which is the due process considerations of the complete deprivation of an

appeal process for a denial of a reopening request, should be considered by the Court in deciding this case.

(e) **Equal Access to Justice Act, 5 U.S.C. 504 and 28 U.S.C. 2412**

The respondent asserts that there is no basis for the petitioner's request for a review of whether the Secretary's position in this case is "substantially justified" under the Equal Access to Justice Act, 5 U.S.C. 504 and 28 U.S.C. 2412 because the petitioner has not filed a fee application in this case and therefore the lower courts had no occasion to address this question. Changes in reimbursement for home health agencies which are occurring during this cost reporting period now make the question of an award of attorney's fees appropriate at this time. Therefore, the petitioner asserts the Court should consider the question of whether or not the Secretary's position can be substantially justified in regard to the attorney's fees related to this proceeding.

---

**CONCLUSION**

The petition for a writ of certiorari should be granted and the questions presented for review as stated in the petition should be addressed.

Respectfully submitted,

DIANA L. GUSTIN  
*Counsel of Record*  
11 Town Square  
Post Office Box 1349  
Norris, Tennessee 37828  
(423) 494-3000  
*Counsel for Petitioner*

(3)  
No. 97-1489

Supreme Court, U.S.  
FILED

JUL 22 1998

OFFICE OF THE CLERK

In The  
**Supreme Court of the United States**

October Term, 1997

YOUR HOME VISITING NURSE SERVICES, INC.,

*Petitioner,*

v.

SECRETARY OF HHS,

*Respondent.*

On Writ Of Certiorari  
To The United States Court Of Appeals  
For The Sixth Circuit

**JOINT APPENDIX**

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(202) 514-2217  
*Counsel for Respondent*

**Petition for Certiorari Filed March 11, 1998**  
**Certiorari Granted June 15, 1998**

## EDITOR'S NOTE

THE FOLLOWING PAGES WERE POOR HARD COPY  
AT THE TIME OF FILMING. IF AND WHEN A  
BETTER COPY CAN BE OBTAINED, A NEW FICHE  
WILL BE ISSUED.

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Certiorari and are therefore not reprinted in this Joint Appen-  
dix.

Proceedings include all events.

3:95cv276 Your Home Vist Nurse v. HHS

TERMED

49BC

JKK

TERMED 49BC

JKK

U.S. District Court  
Eastern District of Tennessee (Knoxville)

CIVIL DOCKET FOR CASE #: 95-CV-276

Your Home Vist Nurse v. HHS

Filed: 05/18/95

Assigned to: Honorable Leon Jordan

Demand: \$49,000

Nature of Suit: 151

Lead Docket: None

Jurisdiction: US Defendant

Dkt# in other court: None

Cause: 42:1395 HHS: Adverse Reimbursement Review

- 5/18/95    1   COMPLAINT (Summons(es) issued),  
Magistrate Judge Thomas W. Phillips des-  
ignated for pretrial matters (cs)
- 5/18/95    -   FILING FEE PAID on 5/18/95 in the  
amount of \$120.00, receipt #001960. (cs)
- 5/30/95    2   RETURN OF SERVICE executed upon U.  
S. Attorney on 5/18/95 by personal ser-  
vice (cs)
- 5/31/95    3   RETURN OF SERVICE executed upon  
defendant HHS on 5/22/95, upon Attor-  
ney General 5/22/95 by cert mail (cs)
- 7/17/95    4   MOTION by defendant to extend time to  
answer C/S (cs) [Entry date 07/18/95]
- 7/20/95    -   ORDER by Honorable Leon Jordan grant-  
ing motion to extend time to answer for  
additional ten days (granted in margin)  
[4-1] (cc: all counsel) (cs)

- 7/31/95 5 MOTION by defendant to dismiss or, in the alternative, for summary judgment; transcript. C/S (cs) [Entry date 08/01/95]
- 7/31/95 6 MEMORANDUM IN SUPPORT of motion to dismiss [5-11, of motion for summary judgment [5-2] C/S (cs) [Entry date 08/01/95]
- 8/23/95 7 RESPONSE by plaintiff Your Home Visting Nurse to deft's motion to dismiss or in the alternative motion for summary judgment [doc. 5], w/attachmnts C/S (dj)
- 9/5/95 8 MOTION by defendant HHS to extendi [sic] time to file a reply to the response of pltf to the deft's motion to dismiss C/S (crs) [Entry date 09/06/95]
- 9/11/95 - ORDER by Honorable Leon Jordan granting defendant's motion for enlargement of time until 9/12/95 (granted in margin) [8-1] (cc: all counsel) (cs)
- 9/11/95 9 REPLY by defendant to plaintiff's response to defendant's motion to dismiss [5-1] or, in the alternative, for summary judgment [5-2] C/S (cs)
- 10/20/95 10 ORDER by Honorable Leon Jordan setting hearing on motion to dismiss [5-1] 9:00 11/30/95 (cc: all counsel) (jj2)
- 10/20/95 - NOTICE OF HEARING on oral argument on motion to dismiss on 11/30/95 at 9:00 before Judge Jordan (cc: all counsel) (jj2)
- 11/30/95 11 CTRM MINUTES (USDJ Jordan): Motion hearing 11/30/95; defendant's motion to dismiss [5-1] heard and taken under advisement; order to follow. Gail Preston,

- DC; Netta Kocuba, CR. (cs) [Entry date 12/01/95]
- 3/22/96 12 MEMORANDUM OPINION by Honorable Leon Jordan in support of the following order (cc: all counsel) (cs)
- 3/22/96 13 ORDER by Honorable Leon Jordan granting defendant's motion to dismiss [5-1] or for summary judgment [5-2] dismissing all claims against defendant. OB 158 Pg 40 (cc: all counsel) (cs)
- 4/10/96 14 NOTICE OF APPEAL by plaintiff from Dist. Court decision entered 3/22/96, dismissing plaintiff's claims (cc: all counsel) (cs) [Entry date 04/11/96]
- 4/10/96 - RECEIVED re [14-1] fee in amount of \$105.00 (Receipt #003470) (cs) [Entry date 04/11/96]
- 4/11/96 15 TRANSCRIPT Order by plaintiff Your Home Vist Nurse for dates: 11/30/95 (cs)
- 4/12/96 - TRANSMISSION FORM - forwarding certified copies of notice of appeal, updated docket entries to USCA: [14-1] (cc: all counsel, i.e. Diana L. Gustin, 800 South Gay Street, Suite 2001, Knoxville, TN 37929; D. Gregory Weddle, Office of the U S Attorney, P O Box 872, Knoxville, TN 37901-0872; and Howard H Lewis, SSA Regional Counsel, 101 Marietta Tower, Suite 521, Atlanta, GA 30323) (cs)
- 4/16/96 16 TRANSCRIPT of proceedings held on 11/30/95 before the Honorable Leon Jordan, CR N. Kocuba. (cs) [Entry date 04/18/96]

4/19/96 17 DESIGNATION OF RECORD by plaintiff  
C/S (cs)

4/29/96 - NOTIFICATION by Circuit Court of  
Appellate Docket Number 96-5525 (cs)

4/15/97 - RECORD on Appeal sent to USCA re  
[14-1] (cc: all counsel) (jn)

2/23/98 18 JUDGMENT from USCA affirming the  
decision of the District Court [14-1]  
attached is a copy of the Full Text Pub-  
lication (jn) [Entry date 02/24/98]

3/3/98 - RECORD on appeal returned from USCA  
(aa)

3/23/98 - LETTER from Supreme Court of the U.S.  
stating that the petition for a writ of cer-  
tiorari was filed on 3/11/98 and place on  
the docket the same day as No. 97-1489  
(dj) [Entry date 03/24/98]

---

**General Docket  
Sixth Circuit Court of Appeals**

**96-5525**

Filed: 4/24/96

Court of Appeals Docket #: 96-5525  
Nsuit: 2151 Contract: Recovery Medicare  
Your Home Visiting v. HHS

Appeal from: Eastern District of Tennessee at Knoxville

Case Type information:

- 1) Civil
- 2) United States Party
- 3) federal question

Lower court information:

District: 0649-3: 95-00276  
Court Reporter: Donnetta Kocuba  
Trial Judge: Leon Jordan, District Judge  
Date Filed: 5/18/95  
Date order/judgment: 3/22/96  
Date NOA filed: 4/10/96

Fee status: paid

Prior cases:

None

Current cases:

None

YOUR HOME VISITING  
NURSE SERVICES, INC.

Plaintiff - Appellant

v.

SECRETARY OF HEALTH  
AND HUMAN SERVICES

Defendant - Appellee

Diane L. Gustin

FTS 523-4738

615-523-5545

[COR LD NTC ret]

800 S. Gay Street

Suite 2001 Plaza Tower

Knoxville, TN 37929

Howard H. Lewis

404-562-1028

[COR LD NTC gvt]

Social Security

Administration

Office of General Counsel

61 Forsyth Street, S.W.

Suite 20T45

Atlanta, GA 30303

D. Gregory Weddle,

Asst. U.S. Attorney

423-545-4167

[COR gvt]

Office of

the U.S. Attorney

800 Market Street

Suite 211

Knoxville, TN 37902

4/24/96 Civil Case Docketed. Notice filed by Appellant Your Home Visiting. Transcript needed: y (pje)

4/24/96 TRANSCRIPT ORDER FORM filed by Diane L. Gustin for Appellant Your Home Visiting: court reporter Donnetta Kocuba, transcript ordered on 4/10/96 [96-5525] [1316117-1] response due by 5/6/96 for Donnetta Kocuba [96-5525] (blh)

4/25/96 TRANSCRIPT ORDER completed by court reporter Donnetta Kocuba for Document [1316117-1] transcript involving, Diane L. Gustin, Donnetta Kocuba. Number of pages: 25 (1 vol) filed in DC on 4/16/96. [96-5525] (blh)

5/1/96 BRIEFING LETTER SENT setting briefing schedule: appellant brief due 6/10/96; appellee brief and administrative record in lieu of appendix due 7/10/96; reply brief due 7/24/96 [96-5525] (pje)

5/7/96 APPEARANCE filed by Attorney Diane L. Gustin for Appellant Your Home Visiting [96-5525] (pje)

5/7/96 PRE-ARGUMENT STATEMENT filed by Diane L. Gustin for Appellant YOUR HOME VISITING [96-5525] (pje)

5/8/96 APPEARANCE filed by Attorney D. Gregory Weddle for Appellee HHS [96-5525] (pje)

5/8/96 APPEARANCE filed by Attorney Howard H. Lewis for Appellee HHS [96-5525] (pje)

5/13/96 Briefing Letter Sent by CONFERENCE ATTORNEY'S OFFICE resetting briefing schedule: appellant brief due now 6/20/96; appellee brief now due 7/22/96; reply now due 8/5/96 appendix now due 8/12/96 [96-5525] . (trm)

5/22/96 Briefing Letter Sent by CONFERENCE ATTORNEY'S OFFICE resetting briefing schedule: appellant brief due now 7/5/96; appellee brief now due 8/5/96; reply now due 8/19/96; appendix now due 8/26/96 [96-5525] . (trm)

- 6/10/96 Briefing Letter Sent by CONFERENCE ATTORNEY'S OFFICE resetting briefing schedule: appellant brief due now 7/19/96; appellee brief now due 8/19/96; reply now due 9/3/96; appendix now due 9/10/96 [96-5525] . (trm)
- 7/9/96 Briefing Letter Sent by CONFERENCE ATTORNEY'S OFFICE resetting briefing schedule: appellant brief due now 8/2/96; appellee brief now due 9/3/96; reply brief now due 9/17/96; appendix now due 9/24/96 [96-5525] . (wjr)
- 7/18/96 Pre-Argument Conference work complete. (wjr)
- 8/1/96 BRIEF filed by Diane L. Gustin for Appellant Your Home Visiting. Copies: 5. Certificate of service date 7/31/96 Number of Pages: 37. [96-5525] (teb)
- 8/1/96 Request to require oral argument filed by Diane L. Gustin for Appellant Your Home Visiting [96-5525] (teb)
- 8/1/96 BRIEFING LETTER SENT requesting brief corrections from Diane L. Gustin because of references, cover, exhibits. Corrections due: 8/15/96. (teb)
- 8/13/96 Corrected appellant brief filed by Diane L. Gustin. Copies: 5. Certificate of Service date 8/12/96 [96-5525] (teb)
- 9/3/96 BRIEF filed by Howard H. Lewis for Appellee HHS. Copies: 6. Certificate of service date 8/31/96. Number of Pages: 35. [96-5525] (teb)
- 9/3/96 Request to waive oral argument and submit case on the briefs, (waiver on page: 1), filed

- by Howard H. Lewis for Appellees HHS [96-5525] (teb)
- 9/17/96 REPLY BRIEF filed by Diane L. Gustin for Appellant Your Home Visiting Copies: 5. Certificate of service date 9/16/96 [96-5525] (teb)
- 9/26/96 APPENDIX filed by Diane L. Gustin for Appellant. Copies: 5. Certificate of Service date 9/23/96 [96-5525] (pje)
- 4/3/97 Appellant MOTION to request addition of document as exhibit (documents not part of lower court record) filed by Diane L. Gustin for Appellant Your Home Visiting. Certificate of service date 3/31/97 [96-5525] (pje)
- 4/8/97 Oral argument date set for 6/5/97 in court room 403. Notice of argument sent to counsel. [96-5525] (paw)
- 4/10/97 Appellee's RESPONSE in opposition to appellant's motion to request addition of document as exhibit previously filed by Diane L. Gustin for the appellant. Response from Howard H. Lewis for Appellee HHS. Certificate of service date 4/9/97 [96-5525] (pje)
- 4/17/97 CERTIFIED RECORD filed. Volumes include 1 tr; 1 Pl. [96-5525] (mrs)
- 4/17/97 ORDER filed referring to hearing panel appellant's motion to request addition of document as an exhibit filed by Diane L. Gustin and appellee's response in opposition thereto. [96-5525] Entered by order of the court. (pje)
- 5/23/97 ADDITIONAL CITATION filed by Diane L. Gustin for Appellant Your Home Visiting. Certificate of service date 5/21/97 [96-5525] (pje)

- 6/2//97 ADDITIONAL CITATION filed by Howard H. Lewis for Appellee HHS. Certificate of service date 5/29/97 [96-5525] (mcp)
- 6/5/97 CAUSE ARGUED on 6/5/97 by Diane L. Gustin for Appellant Your Home Visiting, Howard H. Lewis for Appellee HHS before Judges Lively, Merritt, Suhrheinrich. [96-5525] (paw)
- 12/22/97 OPINION filed: AFFIRMED, decision for publication pursuant to local rule 24 [96-5525]. Pierce Lively, Circuit Judge, Gilbert S. Merritt, Authoring Judge, Richard F. Suhrheinrich, Circuit Judge. (pje)
- 12/22/97 JUDGMENT: AFFIRMED. (pje)
- 2/20/98 MANDATE ISSUED with no cost taxed [96-5525] (pje)
- 2/27/98 CERTIFIED RECORD RETURNED to lower court at the end of appellate proceedings. [96-5525] . Volumes included: 1 Pl; 1 Tr;. (mrs)
- 3/9/98 Record acknowledgment received from the district court. Acknowledged by: Acknowledgment date: [96-5525] (mrs)
- 3/16/98 U.S. Supreme Court notice filed regarding petition for writ of certiorari filed by Appellant Your Home Visiting. Filed in the Supreme Court on 03-11-98. Supreme Ct. case number: 97-1489. [96-5525] (swh)
- 6/18/98 U.S. Supreme Court letter filed granting petition for writ of certiorari limited to Questions 1 and 2 presented by the petition. [1693813-1] filed by Your Home Visiting Nurse Services, Inc. [96-5525] . Filed in the Supreme Court on 06-15-98 (swh)

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF TENNESSEE  
NORTHERN DIVISION

YOUR HOME VISITING NURSE	)	
SERVICES, INC.,	)	
	)	
Plaintiff,	)	Civil Action No.
vs.	)	3:95-CV-276
	)	
DONNA E. SHALALA,	)	
SECRETARY, DEPARTMENT OF	)	
HEALTH AND HUMAN	)	
SERVICES,	)	
	)	
Defendant.	)	

CERTIFICATION

(Received July 10, 1995)

I, Jacqueline R. Vaughn, Acting Attorney Advisor, Health Care Financing Administration, Department of Health and Human Services, under authority delegated by the Secretary, certify that the documents attached constitute a true and accurate transcript of the official file as furnished by the Provider Reimbursement Review Board (PRRB). These documents are the records of the PRRB's denial of jurisdiction, concerning the request for hearing by Your Home Visiting Nurse Services, Inc., for fiscal year ending December 31, 1989, under Title XVIII of the Social security Act, as amended.

Date: July 6, 1995

/s/ Jacqueline R. Vaughn  
Jacqueline R. Vaughn

YOUR HOME VISITING NURSE SERVICES, INC.

CASE NO. 95-0006G

COURT TRANSCRIPT INDEX

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PRRB Letter, Dated March 14, 1995, Enclosing Original PRRB Documents, Dated January 10, 1995, Denying Jurisdiction and advising of Dismissal of Case, Which Had Been Returned to PRRB Due to Provider's Change of Address	1-6
Provider's Letter, Dated October 14, 1994, Requesting Review Of Intermediary's Refusal To Reopen Cost Report, With Supporting Documentation	7-33

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PROVIDER REIMBURSEMENT REVIEW BOARD  
6660 Security Boulevard  
Baltimore, Maryland 21207

REFER TO	Location: Professional Bldg.
95-0006G	Room 104
<u>CERTIFIED MAIL</u>	

MAR 14 1995

Diana L. Gustin, Esq.  
Plaza Tower  
Suite 2001  
800 South Gay Street  
Knoxville, TN 37929

RE: Your Home Visiting Nurse Services, Inc. Denial of  
the Reopening Group Appeal  
Provider Nos. 44-H003, 44-7100, 44-7234, 44-7304  
FYE 12/31/89  
PRRB Case No. 95-0006G

Dear Ms. Gustin:

The enclosed correspondence was returned to the office  
of the Provider Reimbursement Review Board incident to  
your change of address. We are forwarding the original  
jurisdictional determination and enclosures to you at the  
most recent address in our computerized docket.

If you have any questions regarding this matter, please  
contact Melanie Marolf-Fetchik at the address above or  
by telephoning (410) 966-5599.

Sincerely,

/s/ Steven Kirsh  
Steven Kirsh  
Acting Director  
Jurisdiction & Case  
Management Staff

Enclosure: Letter of 1/10/95

cc: Bessie T. Wheeler, BC/BS of S. Carolina  
Wilson Leong, BCBSA

---

Section 1878(f) of the Act permits a provider to obtain judicial review of a final decision of the

Board, or of a reversal, affirmation, or modification by the Administrator of a Board decision, by filing a civil action pursuant to the Federal Rules of Civil Procedure within 60 days of the date on which the provider received notice of -

- (1) A final decision by the Board; or
- (2) Any reversal, affirmance, or modification by the Administrator.

The Board's decision is not final if the Administrator reverses, affirms or modifies the decision within 60 days of the date on which the provider received notice of the decision.

(b) Administrator declines to review a Board decision.

If the Administrator declines to review a Board decision, the provider must file its appeal within 60 days of receipt of the decision of the Board.

(c) Administrator does not act after reviewing a Board decision.

If the Administrator notifies the parties that he or she has decided to review a Board decision and then does not make a decision within the 60 days allotted for his or her review, this subsequent inaction constitutes an affirmance allowing a provider an additional 60 days in which to file for judicial review, beginning with the date the Administrator's time expires for taking action under §405.1875(g)(2).

(d) Matters not subject to judicial review.

Certain matters affecting payments to hospital under the prospective payment system are not subject to judicial review, as provided in section 1886(d)(7) of the Act and §405.1804.

(e) Group appeals.

Any action under this section by providers that are under common ownership or control (see §405.427) must be brought by the providers as a group with respect to any matter involving an issue common to the providers.

(f) Venue for appeals.

An action for judicial review must be brought in the District Court of the United States for the judicial district in which the provider is located (or, effective April 20, 1983, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia. Effective April 20, 1983, any action for judicial review by providers under common ownership or control (§405.427), must be brought by such providers as a group with respect to any matter involving an issue common to the providers.

(g) Service of process.

Process must be served as described under 45 CFR Part 4.

[41 Fr 52051, Nov. 26, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977 amended at 48 FR 39836, Sept. 1, 1983; 48 FR 45774, Oct. 7, 1983]

Illegible  
Reimbursement Determination and Appeals  
 Revised: Federal Register/Vol. 48, 196/Fr. 10-7-83

**§405.1875 Administrator's review.**

(a) *General rule.* (1) Except for a Board determination under § 405.1842 that it lacks the authority to decide an issue, the Administrator, at his or her discretion, may review any final decision of the Board, including a decision under § 405.1873 about the Board's jurisdiction to grant a hearing. The administrator may exercise this discretion on his or her own motion, in response to a request from a party to a Board hearing or in response to a request from HCFA.

(2) The Office of the Attorney Advisory will examine the Board's decisions, the requests made by a party or HCFA and any submission made in accordance with the provisions of this section in order to assist the Administrator in deciding whether to exercise this review authority.

(b) *Request for review.* A party or HCFA requesting the Administrator to review a Board decision must file a written request with the Administrator within 15 days of the receipt of the Board decision.

(c) *Criteria for deciding whether to review.* In deciding whether to review a Board decision, either on his or her own motion or in response to a request from a party to the hearing or HCFA, the Administrator will normally consider whether it appears that:

(1) The Board made an erroneous interpretation of law, regulation or HCFA Ruling;

(2) The Board's decision is not supported by substantial evidence; or

(3) The case presents a significant policy issue having a basis in law and regulations, and review is likely to lead to the issuance of a HCFA Ruling or other directive needed to clarify a statutory or regulatory provision;

(4) The Board has incorrectly assumed or denied jurisdiction or extended its authority to a degree not provided for by statute, regulation or HCFA Ruling; and

(5) The decision of the Board requires clarification, amplification, or an alternative legal basis for the decision.

(d) *Decision to review.* (1) Whether or not a party or HCFA has requested review, the Administrator will promptly notify the parties and HCFA whether he or she has decided to review a decision of the Board and, if so, will indicate the particular issues he or she will consider.

(2) The Administrator may decline to review a case or any issue in a case even if a party has filed a written request for review under paragraph (b) of this section.

(e) *Written submissions.* (1) Within 15 days of receipt of a notice that the Administrator has decided to review a Board decision a party or HCFA may submit to the Administrator, in writing:

(i) Proposed findings and conclusions;

(ii) Supporting views or exceptions to the Board decision;

(iii) Supporting reasons for the exceptions and proposed findings; and

(iv) A rebuttal of the other party's request for review or other submissions already filed with the Administrator.

(2) These submissions shall be limited to issues the Administrator has decided to review and confined to the record of the Board hearing.

(3) A party or HCFA, within 15 days of receipt of a notice that the Administrator has decided to review a decision, may also request that the decision be remanded and state reasons for doing so. Reasons for a request to remand may include [sic] new, substantial evidence concerning -

(i) Issues presented to the Board; and

(ii) New issues that have arisen since the case was presented to the Board.

(4) A copy of any written submission made under this paragraph shall be sent simultaneously to each other party to the Board hearing and to HCFA, if HCFA has previously -

(i) Requested that the Administrator review a Board decision or filed a written submission in response to a party's request for review.

(ii) Responded to a party's request for review; or

(iii) Submitted material after the Administrator has announced that he or she will review a Board decision.

(f) *Ex parte communications prohibited.* All communications from any of the parties or HCFA about a Board decision being reviewed by the Administrator must be in

writing and must contain a certification that copies have been served on the parties and HCFA, as appropriate. The Administrator will not consider any communication that does not meet these requirements or is not submitted within the required time limits.

(g) *Administrator's decision.* (1) If the Administrator has notified the parties and HCFA that he or she has decided to review a Board decision, the Administrator will affirm, reverse, modify or remand the case.

(2) The Administrator will make this decision within 60 days after the provider received notification of the Board decision and will promptly mail a copy of the decision to each party and to HCFA.

(3) Any decision other than to remand will be confined to -

(i) The record of the Board, as forwarded by the Board;

(ii) \* \* \*

(iii) Generally known facts that are not subject to reasonable dispute.

(4) The Administrator may rely on prior decisions of the Board, the Administrator and the courts, and other applicable law, whether or not cited by the parties and HCFA.

(h) *Remand.* (1) A remand to the Board by the Administrator vacates the Board's decision.

(2) The Administrator may direct the Board to take further action with respect to the development of additional

facts, new issues, or to consider the applicability of laws or regulations other than those considered by the Board. The following are not acceptable bases for remand -

(i) Presentation of evidence existing at the time of the Board hearing that was known or reasonably could have been known;

(ii) Introduction of a favorable court case that was either not available in print at the time of the Board hearing or was decided after the Board hearing;

(iii) Change of a party's representation before the Board;

(iv) Presentation of an alternative legal basis concerning an issue in dispute; or

(v) Attempted retraction of a waiver of a right made before or at the Board hearing.

(3) After remand, the Board will take the action requested in the remand action and issue a new decision.

(4) The new decision will be final unless the Administrator reverses, affirms, modifies, or against remands the decision in accordance with the provisions of the section.

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*Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy*

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days

after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court

of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue \* \* \*

- (2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the fiscal month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal the rate of return on equity capital established by regulation pursuant to section 1395x(v)(1)(B) of this title as in effect at the time the civil action authorized and paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.
- (3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

LONDON & AMBURN, P.C.  
ATTORNEYS AND COUNSELORS AT LAW  
1716 CLINCH AVENUE  
KNOXVILLE, TENNESSEE 37916  
TELEPHONE (615) 637-0203  
TELEFAX (615) 637-4850

[Names Omitted In Printing]

October 14, 1994

**VIA CERTIFIED MAIL NO. Z 150 274 778**

Provider Reimbursement Review Board  
Department of Health and Human Services  
6660 Security Blvd.  
Baltimore, Maryland 21207

Re: Your Home Visiting Nurse Services, Inc.  
Providers # 44-H003, 44-7100, 44-7300, 44-7234,  
44-7304  
FYE 12/31/89

**REQUEST FOR REVIEW OF INTERMEDIARY'S  
REFUSAL TO RE-OPEN COST REPORT**

(Received Oct. 17, 1994)

Attention Provider Reimbursement Review Board Chairman:

This is a request for Board review of the Providers' Request for Re-opening which was denied by the Intermediary on April 21, 1994. 42 CFR Section 405.1885 specifically grants jurisdiction for reopening a determination to revise any matter at issue. In *State of Oregon v. Bowen*, U.S. court of Appeals for the Ninth Circuit, No. 86-4369, August 18, 1988, the Ninth Circuit Court recognized an

intermediary's denial of a request to reopen as a reviewable decision if the request for review of the refusal to reopen is brought within the 180-day time period set forth in Section 1878 of the Act.

Accordingly, this request for review of the Intermediary's refusal to reopen is being filed within 180 days of the Intermediary's refusal to reopen. Attached hereto in support of this request for review is the Request for Reopening and the attachments filed therewith, and the Intermediary's response to that request.

The Providers assert that the refusal to reopen is an abuse of discretion in that there is new and material evidence which was presented to Blue Cross and Blue Shield of South Carolina, the present Intermediary, which shows that a clear and obvious error was made in the determination of the allowable amounts of owners compensation for 12/31/89.

The Providers assert that the determination was inconsistent with the law, regulations and rulings and general instructions in that the base rate of owners' compensation set by Blue Cross and Blue Shield of Tennessee, the previous Intermediary, and then followed by the present Intermediary, did not use comparable salary data it had in its possession for home office officers of a chain operations when setting the allowable salary for the home office officers (owners) of Your Home Visiting Nurse Services, Inc., which is and was in 1989 a chain of home health care agencies.

This information was not known by the Providers until 1994 during negotiations with Blue Cross and Blue Shield of South Carolina in regard to the owners compensation

issue. During conversations with personnel from Blue Cross and Blue Shield of Tennessee it was revealed that Your Home Visiting Nurse Services, Inc was treated like a large home health agency as opposed to a chain operation with a home office for purposes of calculating the allowable amount of owners compensation.

Based upon this newly discovered evidence, the request for reopening was made. This request was denied, which the Providers assert was an abuse of discretion which prompted this request for Board review.

Respectfully submitted,

/s/ Diana L. Gustin  
Diana L. Gustin

Enclosures

cc: Blue Cross and Blue Shield of South Carolina  
Betty Leake, YHVNS

---

**Medicare**

Audit and Reimbursement  
Post Office Box 100190  
Columbia, South Carolina 29202

April 21, 1994

Ms. Diana L. Gustin  
London & Amburn, P.C.  
1716 Clinch Avenue  
Knoxville, Tennessee 37916

Re: Your Home Visiting Nurse Service, Inc.  
Provider No: 44-7100, 44-7300, 44-7234, 44-7304  
FYE: December 31, 1989  
(Received Oct. 17, 1994)

Dear Ms. Gustin:

I am writing in response to your letter of March 28, 1994, which was addressed to Bruce Hughes. In this letter, you requested a reopening of the 1989 cost reports of Your Home Visiting Nurse Service, Inc., to increase the amount of owners' compensation. The compensation contained on the settled cost reports is the amount that was initially claimed when the cost reports were filed.

A request for reopening can be granted for several reasons. These reasons, as stated in Section 2931.2 of HCFA Publication 15-1, are:

new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions.

Your request for reopening is denied. The manner in which the home office cost statement was filed was not inconsistent with the law, regulations and rulings or general instructions. A clear and obvious error was not made when these cost reports were filed. And, new and material evidence has not been presented to establish that the compensation claimed was inappropriate.

If you have any questions, you may contact me at (803) 788-0222, extension 1252.

Sincerely,

/s/ Jim Peebles  
Jim Peebles  
Audit Manager  
Medicare Audit and Reimbursement

cc: Bruce Hughes, Medicare Administration  
Sharon Roberts, Medicare Audit and Reimbursement  
Bessie Wheeler, Medicare Audit and Reimbursement  
Pat Anderson, Medicare Audit and Reimbursement

---

LONDON & AMBURN, P.C.  
ATTORNEYS AND COUNSELORS AT LAW  
1716 CLINCH AVENUE  
KNOXVILLE, TENNESSEE 37916  
TELEPHONE (615) 637-0203  
TELEFAX (615) 637-4850

[Names Omitted In Printing]

TO: Bruce Hughes  
FROM: Diana L. Gustin FAXPHONE # (803) 788-8240  
DATE: 03/28/94 TOTAL NUMBER PAGES  
TIME: 3:40 p.m. (INCLUDING COVER  
PAGE): 4

COMMENTS: See attached correspondence.  
Please report any problems in transmission to (615)  
637-0203

Confidentiality Clause

The information contained in this facsimile message is legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this telecopy is prohibited. If you have received this telecopy in error, please immediately notify us by telephone and return the original message to us at the address above via the United States Postal service. We will reimburse for the cost of postage.

Thank you  
FAXFORM

LONDON & AMBURN, P.C.  
ATTORNEYS AND COUNSELORS AT LAW  
1716 CLINCH AVE.  
KNOXVILLE, TENNESSEE 37916  
TELEPHONE (615) 637-0203  
TELEFAX (615) 637-4850

[Names Omitted In Printing]

March 28, 1994

VIA FAX AND FEDERAL EXPRESS

Mr. Bruce Hughes  
Medicare Audit & Reimbursement  
Blue Cross & Blue Shield of South Carolina  
P.O. Box 100190  
Columbia, South Carolina 29202

Re: Your Home Visiting Nurse Services, Inc.  
Provider # 44-H003, 44-7100, 44-7300, 44-7234,  
44-7304  
FYE 12/31/89  
PROVIDERS' REQUEST FOR REOPENING

Dear Mr. Hughes,

I am writing on behalf of the above captioned providers and their home office. These providers are presently negotiating with staff at Blue Cross and Blue Shield of South Carolina regarding owners' compensation at issue for 12/31/87, 12/31/90, 12/31/91, 12/31/92, 12/31/93 and the current year of 12/31/94. During the course of

negotiations it was established that the first year BCBS/SC audited this provider, FYE 12/31/87, certain information from BCBS/TN was used and relied upon by BCBS/SC to make certain audit adjustments. Unbeknownst to the providers at that time, BCBS/TN had knowledge and additional information, which has been described as an informal survey for reasonable compensation for home office officers of home health agency chains, which was relied upon in establishing reasonable compensation for other home health agency owners. Although this information was used by BCBS/TN to establish allowable compensation for *some* home health agency owner's compensation, it was not used when allowable compensation for the above captioned providers' owners salary was determined. Based upon the failure of BCBS/TN to use the available data, the auditors at BCBS/SC made an adjustment to YHVNS to providers which resulted in the home office officers owners compensation at YHVNS being below the amount considered reasonable for other home office officers salary.

The 1987 cost report was closed using an audit adjustment to decrease owners' compensation. The 1989 cost report was prepared after the 1987 cost report was closed. Based upon the auditors adjustments to owners' compensation for the 1987 cost report, the owners listed an amount of compensation as "PROTESTED" on the 1989 cost report.

The providers hereby request re-opening of the 1989 cost report to recompute the allowable owners' compensation based upon the home office officers salary range which

was being used by BCBS/TN for other home health agencies in the State of Tennessee. Attachments to support this request are included in your Federal Express package.

#### 42 Code of Federal Regulations Section 405.1885

#### REOPENING A DETERMINATION OR DECISION

(a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, *or on the motion of the provider affected by such determination or decision* to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision, or where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3 year period except as provided in paragraphs (d) and (e) of this section.

(emphasis added)

Please contact me upon receipt of this letter to advise of your response to this REQUEST FOR REOPENING. I look forward to working with you in resolving this matter.

Sincerely,

/s/ Diana L. Gustin  
Diana L. Gustin

## Enclosures

cc: Mr. William R. Horton, Vice President of Medicare Operations  
 Mr. Jim Peebles, Manager of Medicare Audit & Reimbursement  
 Mr. Gary Bowers, Bowers & Associates, C.P.A.  
 Mrs. Betty Leake, Your Home Visiting Nurse Services, Inc.

**Medicare**

300 Arbor Lake Drive, Suite 900  
 Columbia, South Carolina 29223

March 29, 1991

Ms. Betty S. Leake  
 Your Home Visiting Nurse Service  
 5703-A Broadway  
 Knoxville, Tennessee 37918

RE: NOTICE OF AMOUNT OF MEDICARE PROGRAM  
 REIMBURSEMENT FOR YOUR HOME VISITING  
 NURSE SERVICE COST REPORTING FISCAL YEAR  
 ENDED DECEMBER 31, 1989 PROVIDER NUMBER  
 44-7300

Dear Ms. Leake:

In accordance with Title 42 of the Code of Federal Regulations (42 CFR), Section 405.1803, this is your Notice of Amount of Medicare Program Reimbursement for the cost reporting period indicated above.

The issuance of this Notice establishes the date of the intermediary's determination of the amount of program

reimbursement for the indicated cost reporting period. Under 42 CFR 405.1885 this determination is subject to reopening by the intermediary, either on its own motion or at your request, at any time within three (3) years from the date of this determination to correct the amount of program reimbursement as reflected on page two of this notice. This determination may not be reopened after the expiration of this three (3) year period except as provided in 42 CFR 405.1885.(d).

The adjustments which produce a difference between the intermediary's determination and your initial cost report are explained on the enclosed adjustment report. The adjustment report reflects the individual adjustments made to your cost report and includes appropriate references to and citations of applicable law, regulations and general program instructions used as the basis for these adjustments. If you have any questions concerning the nature of these adjustments or the reasons for them, please contact this office.

As a result of our examination of this cost report, our determination of your Medicare reimbursement for the indicated period is as follows:

Notice of Program Reimbursement  
Page Two

Your Home Visiting Nurse Service  
44-7300  
FYE 12/31/89

HCFA 1728-86, Wkst. B, L. 29, Col. 6      \$ 373,534      \$ 383,278      \$ (9,744)

TOTAL ALLOWABLE COST      \$ 373,534      \$ 383,278      \$ (9,744)

HCFA 1728, Sch. D, Line 26A, Col. 1      \$ 324,514      \$ 359,171      \$ (34,657)  
HCFA 1728, Sch. D, Line 26A, Col. 2      10,968      7,724      3,244  
Sequestration Adjustment      (1,462)      (1,505)      63  
Protested Amounts      -0-      5,675      (5,675)

TOTAL MEDICARE REIMBURSABLE COST      \$ 334,020      \$ 371,065      \$ (37,045)

Less Amount Received and Receivable  
Through Interim Payments:

HCFA 1728, Sch. D, Line 27, Col. 1      \$ 345,975      \$ 345,975      \$ -0-  
HCFA 1728, Sch. D, Line 27, Col. 2      -0-      -0-      -0-

TOTAL INTERIM PAYMENTS      \$ 345,975      \$ 345,975      \$ -0-

Amount Due Provider (Program)  
Per Cost Report      \$ (11,955)      \$ 25,090      \$ (37,045)

Lump-Sum Adjustments  
Previous Settlements      5,166  
NET AMOUNT DUE PROVIDER (PROGRAM)      \$ (6,789)

If you are dissatisfied with our determination and the amount of program reimbursement in controversy is at least \$1,000.00, you have the right to appeal our determination. To exercise your appeal rights, a written request must be filed within one hundred and eighty (180) calendar days of the date of this Notice of Program Reimbursement. An addendum is enclosed with this letter that outlines the procedures for filing an appeal.

Enclosed you will find your copy of the revised Medicare cost report and related documents. If page two of this Notice of Program Reimbursement reflects an amount due to your facility, a check for that amount will be issued within fifteen (15) days. If an amount is due to the Medicare program, a request for repayment accompanies this notice. That letter explains the conditions governing interest assessments on amounts due to the Medicare program.

If our examination of your cost report revealed items for which we were unable to make a final determination at this time, a listing of such items is enclosed. Please review this listing carefully, as these items may result in a future correction of this Notice.

Sincerely,

/s/ John N. Dart  
John N. Dart  
Assistant Vice President  
Medicare Audit and Reimbursement  
JND:slm

Enclosures: 1. Revised Medicare Cost Report with  
Adjustment Report

2. Listing of Identified Items Pending Final Resolution (if applicable)
3. Procedures for filing an appeal

---

**Medicare**

300 Arbor Lake Drive, Suite 900  
Columbia, South Carolina 29223

March 29, 1991

Ms. Betty S. Leake  
Your Home Visiting Nurse Service  
5703-A Broadway  
Knoxville, Tennessee 37918

RE: NOTICE OF AMOUNT OF MEDICARE PROGRAM  
REIMBURSEMENT FOR YOUR HOME VISITING  
NURSE SERVICE COST REPORTING FISCAL YEAR  
ENDED DECEMBER 31, 1989 PROVIDER NUMBER  
44-7304

Dear Ms. Leake:

In accordance with Title 42 of the Code of Federal Regulations (42 CFR), Section 405.1803, this is your Notice of Amount of Medicare Program Reimbursement for the cost reporting period indicated above.

The issuance of this Notice establishes the date of the inter-mediary's determination of the amount of program reimbursement for the indicated cost reporting period. Under 42 CFR 405.1885 this determination is subject to reopening by the intermediary, either on its own motion or at your request, at any time within three (3) years from

the date of this determination to correct the amount of program reimbursement as reflected on page two of this notice. This determination may not be reopened after the expiration of this three (3) year period except as provided in 42 CFR 405.1885.(d).

The adjustments which produce a difference between the inter-mediary's determination and your initial cost report are explained on the enclosed adjustment report. The adjustment report reflects the individual adjustments made to your cost report and includes appropriate references to and citations of applicable law, regulations and general program instructions used as the basis for these adjustments. If you have any questions concerning the nature of these adjustments or the reasons for them, please contact this office.

As a result of our examination of this cost report, our determination of your Medicare reimbursement for the indicated period is as follows:

Notice of Program Reimbursement  
Page Two

19

Your Home Visiting Nurse Service  
44-7304  
FYE 12/31/89

INTERMEDIARY PROVIDER'S DIFFERENCE  
DETERMINATION INITIAL REPORT (DECREASE)

HCFA 1728-86, Wkst. B, L. 29, Col. 6 \$ 613,380 \$ 627,577 \$ (14,197)

TOTAL ALLOWABLE COST \$ 613,380 \$ 627,577 \$ (14,197)

HCFA 1728, Sch. D, Line 26A, Col. 1  
HCFA 1728, Sch. D, Line 26A, Col. 2  
Sequestration Adjustment  
Protested Amount

\$ 549,456 \$ 617,631 \$ (68,177)  
61,304 43,983 (2,679)  
(2,573) (2,638) 65  
-0- 10,227 (10,227)

TOTAL MEDICARE REIMBURSABLE COST \$ 588,185 \$ 669,203 \$ (81,018)

Less Amount Received and Receivable  
Through Interim Payments:

HCFA 1728, Sch. D, Line 27, Col. 1  
HCFA 1728, Sch. D, Line 27, Col. 2

\$ 539,356 \$ 581,132 \$ (41,778)  
38,066 -0- 38,066

TOTAL INTERIM PAYMENTS \$ 577,420 \$ 581,132 \$ (3,712)

Amount Due Provider (Program)  
Per Cost Report

\$ 10,765 \$ 88,071 \$ (77,306)

Lump-Sum Adjustments  
Previous Settlements

(24,367)

NET AMOUNT DUE PROVIDER (PROGRAM)

\$ (13,602)

If you are dissatisfied with our determination and the amount of program reimbursement in controversy is at least \$1,000.00, you have the right to appeal our determination. To exercise your appeal rights, a written request must be filed within one hundred and eighty (180) calendar days of the date of this Notice of Program Reimbursement. An addendum is enclosed with this letter that outlines the procedures for filing an appeal.

Enclosed you will find your copy of the revised Medicare cost report and related documents. If page two of this Notice of Program Reimbursement reflects an amount due to your facility, a check for that amount will be issued within fifteen (15) days. If an amount is due to the Medicare program, a request for repayment accompanies this notice. That letter explains the conditions governing interest assessments on amounts due to the Medicare program.

If our examination of your cost report revealed items for which we were unable to make a final determination at this time, a listing of such items is enclosed. Please review this listing carefully, as these items may result in a future correction of this Notice.

Sincerely,

/s/ John N. Dart  
John N. Dart  
Assistant Vice President  
Medicare Audit and Reimbursement

JND:slm

- Enclosures:
1. Revised Medicare Cost Report with Adjustment Report
  2. Listing of Identified Items Pending Final Resolution (if applicable)
  3. Procedures for filing an appeal

---

**Medicare**

300 Arbor Lake Drive, Suite 900  
Columbia, South Carolina 29223

March 29, 1991

Ms. Betty S. Leake  
Your Home Visiting Nurse Service  
5703-A Broadway  
Knoxville, Tennessee 37918

RE: NOTICE OF AMOUNT OF MEDICARE PROGRAM  
REIMBURSEMENT FOR YOUR HOME VISITING  
NURSE SERVICE COST REPORTING FISCAL YEAR  
ENDED DECEMBER 31, 1989 PROVIDER NUMBER  
44-7100

Dear Ms. Leake:

In accordance with Title 42 of the Code of Federal Regulations (42 CFR), Section 405.1803, this is your Notice of Amount of Medicare Program Reimbursement for the cost reporting period indicated above.

The issuance of this Notice establishes the date of the intermediary's determination of the amount of program reimbursement for the indicated cost reporting period. Under 42 CFR 405.1885 this determination is subject to

reopening by the intermediary, either on its own motion or at your request, at any time within three (3) years from the date of this determination to correct the amount of program reimbursement as reflected on page two of this notice. This determination may not be reopened after the expiration of this three (3) year period except as provided in 42 CFR 405.1885.(d).

The adjustments which produce a difference between the inter-mediary's determination and your initial cost report are explained on the enclosed adjustment report. The adjustment report reflects the individual adjustments made to your cost report and includes appropriate references to and citations of applicable law, regulations and general program instructions used as the basis for these adjustments. If you have any questions concerning the nature of these adjustments or the reasons for them, please contact this office.

As a result of our examination of this cost report, our determination of your Medicare reimbursement for the indicated period is as follows:

Notice of Program Reimbursement  
Page Two

Your Home Visiting Nurse Service  
64-7100  
FYE 12/31/89

	INTERMEDIARY DETERMINATION	PROVIDER'S INITIAL REPORT	DIFFERENCE (DECREASE)
HCFA 1728-86, Wkst. B, L. 29, Col. 6	\$ 692,735	\$ 711,808	\$ (19,073)
<b>TOTAL ALLOWABLE COST</b>	<u>\$ 692,735</u>	<u>\$ 711,808</u>	<u>\$ (19,073)</u>
HCFA 1728, Sch. D, Line 26A, Col. 1	\$ 628,003	\$ 686,513	\$ (58,510)
HCFA 1728, Sch. D, Line 26A, Col. 2	35,297	36,610	(1,113)
Sequestration Adjustment	(2,890)	(2,991)	101
Protected Amounts	<u>-0-</u>	<u>11,431</u>	<u>(11,431)</u>
<b>TOTAL MEDICARE REIMBURSABLE COST</b>	<b>\$ 660,410</b>	<b>\$ 731,363</b>	<b>\$ (70,953)</b>

4

Less Amount Received and Receivable  
Through Interim Payments:

HCFA 1728, Sch. D, Line 27, Col. 1	\$ 705,476	\$ 705,476	\$ -0-
HCFA 1728, Sch. D, Line 27, Col. 2	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<b>TOTAL INTERIM PAYMENTS</b>	<b>\$ 705,476</b>	<b>\$ 705,476</b>	<b>\$ -0-</b>
<b>Amount Due Provider (Program) Per Cost Report</b>	<b>\$ (45,066)</b>	<b>\$ 25,889</b>	<b>\$ (70,953)</b>
<b>Lump-Sum Adjustments Previous Settlements</b>	<u>27,094</u>		
<b>NET AMOUNT DUE PROVIDER (PROGRAM)</b>	<u><b>\$ (17,970)</b></u>		

If you are dissatisfied with our determination and the amount of program reimbursement in controversy is at least \$1,000.00, you have the right to appeal our determination. To exercise your appeal rights, a written request must be filed within one hundred and eighty (180) calendar days of the date of this Notice of Program Reimbursement. An addendum is enclosed with this letter that outlines the procedures for filing an appeal.

Enclosed you will find your copy of the revised Medicare cost report and related documents. If page two of this Notice of Program Reimbursement reflects an amount due to your facility, a check for that amount will be issued within fifteen (15) days. If an amount is due to the Medicare program, a request for repayment accompanies this notice. That letter explains the conditions governing interest assessments on amounts due to the Medicare program.

If our examination of your cost report revealed items for which we were unable to make a final determination at this time, a listing of such items is enclosed. Please review this listing carefully, as these items may result in a future correction of this Notice.

Sincerely,

/s/ John N. Dart  
John N. Dart  
Assistant Vice President  
Medicare Audit and Reimbursement

JND:slm

- Enclosures:
1. Revised Medicare Cost Report with Adjustment Report
  2. Listing of Identified Items Pending Final Resolution (if applicable)
  3. Procedures for filing an appeal

#### Medicare

300 Arbor Lake Drive, Suite 900  
Columbia, South Carolina 29223

March 29, 1991

Ms. Betty S. Leake  
Your Home Visiting Nurse Service  
5703-A Broadway  
Knoxville, Tennessee 37918

RE: NOTICE OF AMOUNT OF MEDICARE PROGRAM  
REIMBURSEMENT FOR YOUR HOME VISITING  
NURSE SERVICE COST REPORTING FISCAL YEAR  
ENDED DECEMBER 31, 1989 PROVIDER NUMBER  
44-7234

Dear Ms. Leake:

In accordance with Title 42 of the Code of Federal Regulations (42 CFR), Section 405.1803, this is your Notice of Amount of Medicare Program Reimbursement for the cost reporting period indicated above.

The issuance of this Notice establishes the date of the inter-mediary's determination of the amount of program reimbursement for the indicated cost reporting period. Under 42 CFR 405.1885 this determination is subject to

reopening by the intermediary, either on its own motion or at your request, at any time within three (3) years from the date of this determination to correct the amount of program reimbursement as reflected on page two of this notice. This determination may not be reopened after the expiration of this three (3) year period except as provided in 42 CFR 405.1885.(d).

The adjustments which produce a difference between the inter-mediary's determination and your initial cost report are explained on the enclosed adjustment report. The adjustment report reflects the individual adjustments made to your cost report and includes appropriate references to and citations of applicable law, regulations and general program instructions used as the basis for these adjustments. If you have any questions concerning the nature of these adjustments or the reasons for them, please contact this office.

As a result of our examination of this cost report, our determination of your Medicare reimbursement for the indicated period is as follows:

Notice of Program Reimbursement  
Page Two

Your Home Visiting Nurse Service  
64-7236  
FYE 12/31/89

HCFA 1728-86, Wkst. B, L. 29, Col. 6	\$1,143,935	\$1,169,034	\$ (25,099)
<b>TOTAL ALLOWABLE COST</b>	<u>\$1,143,935</u>	<u>\$1,169,034</u>	<u>\$ (25,099)</u>

HCFA 1728, Sch. D, Line 26A, Col. 1	\$ 983,038	\$1,055,353	\$ (72,315)
HCFA 1728, Sch. D, Line 26A, Col. 2	86,188	88,784	(2,596)
Sequestration Adjustment	(4,657)	(4,822)	165
Protected Amounts	<u>-0-</u>	<u>19,131</u>	<u>(19,131)</u>

**TOTAL MEDICARE REIMBURSABLE COST** \$1,064,569 \$1,158,446 \$ (93,877)

Less Amount Received and Receivable  
Through Interim Payments:

HCFA 1728, Sch. D, Line 27, Col. 1	\$1,049,517	\$ 1,049,517	\$ -0-
HCFA 1728, Sch. D, Line 27, Col. 2	<u>103</u>	<u>-0-</u>	<u>103</u>
<b>TOTAL INTERIM PAYMENTS</b>	\$1,049,620	\$ 1,049,517	\$ 103

Amount Due Provider (Program)  
Per Cost Report \$ 14,949 \$ 108,929 \$ (93,980)

Lump-Sum Adjustments  
Previous Settlements (38,644)

**NET AMOUNT DUE PROVIDER (PROGRAM)** \$ (23,695)

If you are dissatisfied with our determination and the amount of program reimbursement in controversy is at least \$1,000.00, you have the right to appeal our determination. To exercise your appeal rights, a written request must be filed within one hundred and eighty (180) calendar days of the date of this Notice of Program Reimbursement. An addendum is enclosed with this letter that outlines the procedures for filing an appeal.

Enclosed you will find your copy of the revised Medicare cost report and related documents. If page two of this Notice of Program Reimbursement reflects an amount due to your facility, a check for that amount will be issued within fifteen (15) days. If an amount is due to the Medicare program, a request for repayment accompanies this notice. That letter explains the conditions governing interest assessments on amounts due to the Medicare program.

If our examination of your cost report revealed items for which we were unable to make a final determination at this time, a listing of such items is enclosed. Please review this listing carefully, as these items may result in a future correction of this Notice.

Sincerely,

/s/ John N. Dart  
John N. Dart  
Assistant Vice President  
Medicare Audit and Reimbursement

JND:slm

Enclosures: 1. Revised Medicare Cost Report with Adjustment Report  
2. Listing of Identified Items Pending Final Resolution (if applicable)  
3. Procedures for filing an appeal

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MEDICARE ADJUSTMENTS TO EXPENSES		SCHEDULE C page 2 of 2	
Home Office: YHUNS INC - Holding Co		Reporting Period from: 11/1/89 to: 12/31/89	
Description	•	Amount	Account to be Adjusted (from Schedule B, col. 1)
			Line Account
		1	3
20. Miscellaneous Income	0	(6457)	24 Miscellaneous
21. Amount paid to Southland			
21. disallowed in previous year	A	31555	24 Miscellaneous
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
30.			
31.			
32.			
33.			
34.			
35.			
36.			
37.			
38.			
39.			
40. Total		(71047)	

## • Basis of Adjustment

A - cost

B - revenue received if related cost is unknown (cost recovery items)

**MEDICARE ADJUSTMENTS TO EXPENSES**

page 1 of 2

29

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Form		Reporting Period	
Office: <u>YHUNS Inc. - Holding Co.</u>		from: <u>1/1/89</u> to: <u>12/31/89</u>	
Description	Amount	Account to be Adjusted	
		Line	Account
1. federal/state income tax, franchise tax, and related interest & penalties on late payments (HCFA-Pub. 15-1, section 2122.2)		2	3
2. donations (See HCFA Pub. 15-1, Chapter 6)	A (3403)	15	Taxes / Penalties
3. stock transfers and registrations (HCFA-Pub. 15-1, section 2134.9)			
4. acquisition expenses (HCFA-Pub. 15-1, section 2134.11)			
5. disposal expenses re: nonpatient care assets or subsidiaries (HCFA-Pub. 15-1, section 2102.3)			
6. bad debts (HCFA-Pub. 15-1, section 308)			
7. life insurance premiums where home office is direct/indirect beneficiary (HCFA-Pub. 15-1, section 2130)			
8. annual stockholder meeting expenses (HCFA-Pub. 15-1, section 2134.9)			
9. nonhealth care projects (HCFA-Pub. 15-1, section 2102.3)			
10. noncompetition agreement expenses (HCFA-Pub. 15-1, sections 2105.1/2118.7)			
11. fundraising expenses (HCFA-Pub. 15-1, section 2116.2)			
12. rebates/refunds on expenses (HCFA-Pub. 15-1, section 804)			
13. interest income on unrestricted funds (HCFA-Pub. 15-1, section 224.2)			
14. cost of ownership of assets leased from related organization in lieu of rent (HCFA-Pub. 15-1, section 1006)			
15. related organizations (from Schedule D, Part B, col. 5, line 15 (HCFA-Pub. 15-1, section 1000))			
16. Others (specify) <u>Owners Compensation Block</u>	A (111037)	2	salaries - others
17. <u>Owners Compensation R. Locke</u>	A (377877)	2	salaries - others
18. <u>Amortization of Goodwill</u>	A (10967)	23	Amort. Goodwill
19. <u>IRS Interest</u>	A (16457)	18	Interest Expense

## STATEMENT OF ALLOWABLE COSTS

 Home Office: YAVNS, INC - Holding Co. Reporting Period from: 1/1/89 to: 12/31/89

Account Description	Expenses per Home Office books	Medicare Adjustments (from Sch. C)	Allowable Expenses (col. 1 minus col. 2)	Direct Allocations		Functional Allowable		col. 4
	1	2	3	chain components (from Sch. E)	regional offices* (from Sch. E)	chain components (from Sch. F)	regional offices* (from Sch. F)	
1. salaries - officers	421436	<37877> <11103>	374046			<25297>		374046
2. salaries - others								
3. payroll taxes	27539		27539			<2048>		25491
4. employee benefits	145989		145989			<7124>		138865
5. profit sharing/pension plans								
6. travel/entertainment	8459		8459					8459
7. automobile								
8. depreciation/amortization	6401		6401					6401
9. building rental	22476		22476					22476
10. equipment rental	8405		8405					8405
11. utilities	4570		4570					4570
12. legal and accounting	77837		77837					77837
13. telephone/telegraph	31223		31223					31223
14. insurance	65848		65848					65848

FORM HCFA-287-82

MEDICARE ADJUSTMENTS TO EXPENSES

SCHEDULE C  
page 2 of 2

Home Office: **YHUNS INC - Holding Co** Reporting Period from: **11/1/89** to: **12/31/89**

Description	*	Amount	Account to be Adjusted (from Schedule B, col.1)	
			Line	Account
		1	2	3
20. Miscellaneous Expense	0	(6457)	24	Miscellaneous
21. Amount paid to Southland				
21. disallowed in previous year	A	31555	24	Miscellaneous
22.				
23.				
24.				
25.				
26.				
27.				
28.				
29.				
30.				
31.				
32.				
33.				
34.				
35.				
36.				
37.				
38.				
39.				
40. Total		(71047)		

\* Basis of Adjustment

A - cost

B - revenue received if related cost is unknown (cost recovery items)

# MEDICARE ADJUSTMENTS TO EXPENSES

SCHEDULE C  
page 1 of 2

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Name: YHUNS Inc. - Holding Co. Reporting Period from: 1/1/89 to: 12/31/89

Description	*	Amount	Account to be Adjusted (from Schedule B col. 1)	
			Line	Account
		1	2	3
federal/state income tax, franchise tax, and related interest & penalties on late payments (HCFA-Pub. 15-I, section 2122.2)	A	(3403)	15	Taxes / Licenses
donations (See HCFA Pub. 15-I, Chapter 6)				
stock transfers and registrations (HCFA-Pub. 15-I, section 2134.9)				
acquisition expenses (HCFA-Pub. 15-I, section 2134.11)				
disposal expenses re: nonpatient care assets or subsidiaries (HCFA-Pub. 15-I, section 2102.3)				
bad debts (HCFA-Pub. 15-I, section 308)				
life insurance premiums where home office is direct/indirect beneficiary (HCFA-Pub. 15-I, section 2130)				
annual stockholder meeting expenses (HCFA-Pub. 15-I, section 2134.9)				
nonhealth care projects (HCFA-Pub. 15-I, section 2102.3)				
noncompetition agreement expenses (HCFA-Pub. 15-I, sections 2105.1/2118.7)				
fundraising expenses (HCFA-Pub. 15-I, section 2136.2)				
rebates/refunds on expenses (HCFA-Pub. 15-I, section 804)				
interest income on unrestricted funds (HCFA-Pub. 15-I, section 224.2)				
cost of ownership of assets leased from related organization in lieu of rent (HCFA-Pub. 15-I, section 1006)				
related organizations (from Schedule D, Part B, col. 5, line 15 (HCFA-Pub. 15-I, section 1000))				
Others (specify)	A	(11037)	2	Salaries - others
Owners compensation Blocke	A	(37787)	2	Salaries - others
Owners compensation A. Locke	A	(10967)	20	Amort. Goodwill
Amortization of Goodwill	A	(16457)	18	Interest Expense
IRS Interest				

STATEMENT OF ALLOWABLE COSTS			Home Office: YAVNS, INC - Holding Co.		Reporting Period from: 11/1/89 to: 12/31/89			
Account Description	Expenses per Home Office books	Medicare Adjustments (from Sch. C)	Allowable Expenses (col. 1 minus col. 2)	Direct Allocations chain components (from Sch. E)	regional offices* (from Sch. E)	Functional Allow. chain components (from Sch. F)	regional offices* (from Sch. F)	col. 4, 5, 6, 7, 8
	1	2	3	4	5	6	7	8
1. salaries - officers	422936	37877 11103	374056			25297		37877
2. salaries - others								
3. payroll taxes	27539		27539			2048		25491
4. employee benefits	145989		145989			7126		138863
5. profit sharing/pension plans								
6. travel/entertainment	8459		8459					8459
7. automobile								
8. depreciation/amortization	6401		6401					6401
9. building rental	22476		22476					22476
10. equipment rental	8405		8405					8405
11. utilities	4570		4570					4570
12. legal and accounting	72822		72822					72822
13. telephone/telegraph	31223		31223					31223
14. insurance	65848		65848					65848

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF TENNESSEE  
NORTHERN DIVISION

---

YOUR HOME VISITING NURSE :  
SERVICES, INC., Home Health :  
Care Agencies, Providers :  
licensed as numbers 44-7100, :  
44-7300, 44-7234 and 44-7304, :  
(TN Corporations) :

Plaintiff, :

vs. :

: Civil Action No. \_\_\_\_

SECRETARY OF HEALTH AND :  
HUMAN SERVICES, :

Defendant. :

---

COMPLAINT  
(Filed May 18, 1995)

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Now comes the plaintiff, Your Home Visiting Nurse Services, Inc., and its home health care agency providers, and for cause of action against the defendant, Secretary of Health and Human Services, shows the following:

1. The plaintiff corporation owns and operates four home health care agency providers which are licensed to provide medical services to qualified Medicare beneficiaries, under the Social Security Act, and to receive reimbursement from the Medicare Program for the services rendered. The four home health care agency providers are commonly owned and are operated through their

home office for business administration which is located at 5703 Broadway, Knoxville, Knox County, Tennessee.

2. The Defendant, Secretary of Health and Human Services is ultimately responsible for administration of the Medicare Program through the Health Care Financing Administration (HCFA), which contracts with insurance companies such as Blue Cross and Blue Shield of Tennessee (BCBS/TN) and Blue Cross and Blue Shield of South Carolina (BCBS/SC) to perform reimbursement and review functions in the role of fiscal intermediaries.

3. The Federal Regulation contained at 42 Code of Federal Regulation Section 421.5(b) provides that intermediaries and carriers act on behalf of HCFA in carrying out certain administrative responsibilities and that HCFA is the real party of interest in any litigation involving the administration of the program.

4. This Court has jurisdiction through 28 U.S.C. Section 1361 which confers original jurisdiction on Federal District courts to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff; 28 U.S.C. Section 1331, regarding federal question jurisdiction; and 42 U.S.C. Section 1395oo(f)(1) which grants providers such as the plaintiff's home health care agency providers herein, the right to obtain judicial review of any final decision of the Provider Reimbursement Review Board, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board is received.

5. The plaintiff's providers received final determinations through Notice of Program Reimbursement letters from

the fiscal intermediary, BCBS/SC, for the cost reporting periods of 12/31/89.

6. These Notices of Program Reimbursement gave each plaintiff/provider notice of the final determination of the fiscal intermediary, BCBS/SC, of allowable cost for reimbursement from the Medicare program.

7. Due to a continued disagreement as to the correct amount of owner's compensation and the appropriate amount of Medicare reimbursement therefor, discussions concerning the issue resulted in the plaintiff acquiring additional information concerning the subject on or about March 1994.

8. The present intermediary, BCBS/SC, is now relying upon a base rate of owner's compensation for the plaintiff which was set by the previous intermediary, BCBS/TN.

9. At the time the previous intermediary, BCBS/TN, set the base rate for owner's compensation for the plaintiff, the previous intermediary had in its possession salary data for home office officers of *chain operations* for home health care agency chains.

10. The previous intermediary, BCBS/TN, did not apply the salary data for home office officers of *chain operations* to the home office officers in the plaintiff's chain operation, but instead, treated the home office officers of the plaintiff operation as if they were home office officers of one large provider.

11. Treating the home office officers of the plaintiff's chain operation as if they were home office officers of a single provider agency resulted in a lower amount of

compensation for the plaintiff's home office officers which caused an audit adjustment to reduce the allowable amount of owner's compensation.

12. The current intermediary, BCBS/SC, computes the current home office officers salary (owners compensation) in part by allowing a percentage increase from the base rate which was set by the previous intermediary.

13. The present intermediary's continued reliance upon the base rate set by the previous intermediary, BCBS/TN, results in a lower amount of compensation for the plaintiff's home office officers (the owner's compensation) for the 1989 cost reporting period and for each cost reporting period thereafter.

14. Intermediaries are required to review and apply comparable salary data when making determinations on allowable salary amounts.

15. The previous intermediary, BCBS/TN, had comparable salary data concerning home office officers of chain operations, but did not apply that data to the plaintiff's home office officers of the plaintiff's chain operation.

16. Upon discovery of this new information, the plaintiff requested reopening of the 1989 cost report within the three year time period stated in 42 Code of Federal Regulations Section 405.1885 for correction to the adjustments for owner's compensation in the amount of \$48,890. (Exhibit A)

17. On April 21 1994, the present intermediary, BCBS/SC, denied the request to reopen. (Exhibit B)

18. On October 14, 1994, the plaintiff requested review of the intermediary's refusal to reopen by the Provider Reimbursement Review Board, citing the intermediary's refusal to reopen as an abuse of discretion. (Exhibit C)

19. On March 21, 1995 the plaintiff received the final determination of the Provider Reimbursement Review Board which found that the Board did not have jurisdiction over this appeal and dismissed the case but noted that the determination was subject to the provisions of 42 U.S.C. Section 1395(f) which states that providers shall have the right to obtain judicial review of any final decision of the Board by a civil action commenced within 60 days of the date on which notice of any final decision by the Board is received. (Exhibit D)

20. As a result of the Board decision, this complaint, requesting judicial review of the Board's dismissal, is being filed within 60 days of receipt of the Board decision.

WHEREFORE, the plaintiff requests that this Court remand this case to the Provider Reimbursement Review Board for a decision on the issue of the intermediary's abuse of discretion as alleged in the Request for Review by the Provider Reimbursement Review Board, or in the alternative, to order the intermediary, to reopen the 1989 cost report to correctly apply the comparable salary for home offices officers for chain operations of home health care agencies to the base year information being relied upon and to make such corrections to the following cost reporting periods as necessary to reverse the audit adjustment to owner's compensation and to pay the plaintiff

\$48,890, plus interest, and such other relief as the Court may deem reasonable and just.

Respectfully submitted this the 18th day of May, 1995.

/s/ Diana L. Gustin  
 DIANA L. GUSTIN 010245  
 Plaza Tower, Suite 2001  
 800 South Gay Street  
 Knoxville, TN 37929  
 (615) 523-5545

---

IN THE UNITED STATES DISTRICT COURT  
 FOR THE EASTERN DISTRICT OF TENNESSEE  
 AT KNOXVILLE

YOUR HOME VISITING NURSE	)	
SERVICES, INC.	)	
	)	
Plaintiff,	)	NO. 3:95-CV-276
	)	JUDGE JORDAN
vs.	)	
DONNA E. SHALALA,	)	
SECRETARY OF HEALTH AND	)	
HUMAN SERVICES	)	
	)	
Defendant.	)	

---

MOTION IN SUPPORT OF DEFENDANTS' MOTION  
 TO DISMISS OR IN THE ALTERNATIVE FOR  
 SUMMARY JUDGMENT

COMES NOW the Defendant, Secretary of Health and Human Services, and respectfully moves to dismiss the complaint pursuant to Fed. R. Civ. P. 12(b)(1) and 12(b)(6). In the alternative, the Secretary moves for Summary Judgment pursuant to Fed. R. Civ. P. 56. A memorandum in support of this motion and a transcript of administrative proceedings are attached.

Respectfully submitted,  
 CARL K. KIRKPATRICK  
 UNITED STATES ATTORNEY

/s/ D. Gregory Weddle  
 D. GREGORY WEDDLE  
 ASSISTANT UNITED STATES ATTORNEY  
 Plaza Tower, 7th Floor  
 800 South Gay Street  
 Knoxville, Tennessee 37929  
 615-545-4167

BRUCE R. GRANGER  
CHIEF COUNSEL - REGION IV

/s/ Howard H. Lewis  
HOWARD H. LEWIS  
ASSISTANT REGIONAL COUNSEL  
Office of the General Counsel  
United States Department of  
Health and Human Services  
101 Marietta Tower  
Suite 521  
Atlanta, GA 30323  
404-331-2377, extension 126

[Certificate Of Service Omitted In Printing]

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(9)

No. 97-1489

**FILED**

**JUL 22 1998**

OFFICE OF THE CLERK  
SUPREME COURT, U.S.

**In The  
Supreme Court of the United States  
October Term, 1997**

**YOUR HOME VISITING NURSE SERVICES, INC.,**  
*Petitioner,*

**v.**

**SECRETARY OF HHS,**  
*Respondent.*

**On Writ Of Certiorari  
To The United States Court Of Appeals  
For The Sixth Circuit**

**PETITIONER'S BRIEF ON THE MERITS**

**DIANA L. GUSTIN**  
*Counsel of Record*  
11 Town Square  
Post Office Box 1349  
Norris, Tennessee 37828  
(423) 494-3000  
*Counsel for Petitioner*

61 pp

**QUESTIONS PRESENTED FOR REVIEW**

- I. Is regulation 42 C.F.R. § 405.1885(c) based on a permissible construction of the Medicare statute?
- II. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under:
  - Provider Reimbursement Review Board statute, 42 U.S.C. § 1395oo?
  - Federal Question Jurisdiction, 28 U.S.C. § 1331?
  - Mandamus Jurisdiction, 28 U.S.C. § 1361?
  - Administrative Procedure Act, 5 U.S.C. § 706?

## PARTIES TO THE PROCEEDINGS

The petitioner, plaintiff-appellant in the proceedings below, is Your Home Visiting Nurse Services, Inc. and its home health care agency providers licensed as numbers 44-7100, 44-7300, 44-7234, and 44-7304 (Tennessee corporations). There is no parent or non-wholly owned subsidiary company to be listed as required by United States Supreme Court Rule 29.6.

Respondent is the Secretary of Health and Human Services, represented by the Solicitor General as Counsel of Record for the Department of Health and Human Services.

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## OPINIONS BELOW

The opinion of the court of appeals is reported at *Your Home Visiting Nurse Services, Inc. v. Secretary of Health and Human Services*, 132 F.3d 1135 (6th Cir. 1997). The opinion of the district court is unreported. See Pet. App. 17-33. The decision of the Provider Reimbursement Review Board is also unreported. See Pet. App. 34-35.

## JURISDICTION

The court of appeals for the Sixth Circuit entered its judgment on December 22, 1997. See Pet. App. 38-39. The petition for a writ of certiorari was filed on March 11, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1). The petition for a writ of certiorari was granted on June 15, 1998 as to the first two questions presented for review within the writ.

 STATUTORY PROVISIONS  
AND OTHER AUTHORITIES INVOLVED

The statutory provisions and other authorities involved include 5 U.S.C. § 706; 28 U.S.C. § 1254(1); 28 U.S.C. § 1331; 28 U.S.C. § 1361; 42 U.S.C. § 405(h); 42 U.S.C. § 1395x(v)(1)(A)(ii); 42 U.S.C. § 1395oo; 42 C.F.R. § 405.1885 *et seq.*; 42 C.F.R. § 421.5(b); and 42 C.F.R. § 413.102(b)(2)(i).

## STATEMENT OF THE CASE

The petitioner provides home health care services to Medicare beneficiaries and is entitled to receive reasonable reimbursement from the Medicare program for these services under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* Part A of the Medicare statute covers basic institutional health costs, including covered home health care. 42 U.S.C. § 1395x(m). The respondent is ultimately responsible for administration of the Medicare Program through the Health Care Financing Administration (HCFA) which contracts with insurance companies such as Blue Cross & Blue Shield of Tennessee and Blue Cross & Blue Shield of South Carolina to perform reimbursement and review functions in the role of fiscal intermediary. See 42 C.F.R. § 421.5(b).

Providers, such as petitioner, submit cost reports to their intermediary at the close of each fiscal year. 42 U.S.C. § 1395g; 42 C.F.R. § 405.1801(b); 42 C.F.R. § 413.24(f). The intermediary then determines allowable cost and issues a Notice of Program Reimbursement letter. 42 C.F.R. § 405.1803. This determination may be reopened under certain circumstances. 42 C.F.R. § 405.1885.

Petitioner discovered new and material evidence concerning its December 31, 1989 cost reports that prompted its request for reopening of the cost reports. The request was made within three years from the date of the Notice of Program Reimbursement letters. The intermediary refused to reopen the cost reports. Pet. App. 36-37. Thereafter, the Provider Reimbursement Review Board (the Board) refused to accept jurisdiction of petitioner's

request for review of the refusal to reopen the cost reports. Pet. App. 34-35. Petitioner appealed the Board's decision to the district court where the case was dismissed and the Board's decision was upheld. Pet. App. 16-33. The district court also refused to accept jurisdiction to hear petitioner's case on any of the alternative theories offered. *Id.* The Sixth Circuit Court of Appeals affirmed the district court decision. Pet. App. 1-15.

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## SUMMARY OF ARGUMENT

The Secretary interprets regulation 42 C.F.R. § 405.1885(c) in such a way that defines exclusive jurisdiction for reopening a report to mean that there is no review of a refusal to reopen a final determination. The petitioner asserts this is not a reasonable interpretation of the Medicare statute and therefore is not a permissible construction of 42 U.S.C. § 1395oo(a). Other sections of the Medicare statute also support the position that review for a refusal to reopen must be allowed. Any other reading of the statute would render provisions regarding retroactive corrective adjustments meaningless and therefore superfluous which would not be in accordance with the statutory scheme taken as a whole. 42 U.S.C. § 1395x(v)(1)(A)(ii).

If there is no review of a refusal by an intermediary to reopen a final determination, then complete power rests with one party. Not only does this conflict with the statutory mandate that regulations *shall* provide for the making of suitable retroactive corrective adjustments, but

it also creates a de facto double standard. This contradiction cannot be construed as a reasonable reading of the Medicare statute.

The Medicare statute, 42 U.S.C. § 1395oo, allows providers to seek review of final determinations. This review process must include those final determinations that are refusals to reopen. The Secretary should not be permitted to extinguish the right to the review procedure set forth in the Medicare statute. If the Court agrees with this contention as the correct reading of the law, then an avenue of administrative review would be available which might dispense with the need to resort to federal question jurisdiction in order to obtain judicial review of a refusal to reopen a final determination. If the Court is not convinced that 42 U.S.C. § 1395oo provides an avenue for administrative appeal of refusals to reopen, then reliance upon 28 U.S.C. § 1331 must again be proposed as a jurisdictional grant for this situation.

It would be implausible to think that Congress intended there be no forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary. In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), this Court severely restricted the decision of *Heckler v. Ringer*, 466 U.S. 602 (1984) when it upheld jurisdiction under 28 U.S.C. § 1331 to challenge the validity of a regulation authorizing payment. Therefore, to the extent that claims involve matters outside the articulated statutory review process, jurisdiction should be available under § 1331. *Medical Fund-Philadelphia Geriatric Center v. Heckler*, 804 F.2d 33, 38-39 (3rd Cir. 1986).

If this Court finds federal question jurisdiction is precluded by 42 U.S.C. § 405(h) of the Medicare statute, then the petitioner would rely upon 28 U.S.C. § 1361 as an alternative for jurisdiction, or in addition to 28 U.S.C. § 1331. This Court has not yet ruled upon the question of whether the third sentence of 42 U.S.C. § 405(h) is a bar to mandamus jurisdiction in Social Security cases. Many Courts of Appeal that have considered the question have ruled that mandamus remains available under the Social Security Act. There are two requirements that must be met regarding mandamus jurisdiction. 28 U.S.C. § 1361. The first pertains to exhaustion of all other avenues of relief and second concerns the breach of a nondiscretionary duty. *Id.* Petitioner asserts it met both requirements and therefore mandamus is a valid basis for jurisdiction in this matter.

Under the Administrative Procedure Act (APA) the Secretary's decisions regarding provider's claims for Medicare reimbursement shall be set aside where a decision is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, or contrary to law. 5 U.S.C. § 706(2)(A). If this Court does not establish a provider's right to obtain review of a refusal to reopen, intermediaries may abuse their discretion and remain unchallenged. The Secretary's reading of 42 C.F.R. § 405.1885(c) precludes review of every decision which refuses to reopen a cost report and therefore insulates from review even the most abhorrent abuses of discretion. There must be a forum with the authority both to review such a decision and to set it aside if the decision is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence, or contrary to law.

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## ARGUMENT

### I. Is 42 C.F.R. § 405.1885(c) based on a permissible construction of the Medicare Act?

The regulation at issue in this case is 42 C.F.R. § 405.1885(c) which states that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." The Secretary interprets her regulation in such a way that defines exclusive jurisdiction for reopening to mean that there is no review of the decision concerning the reopening request. The petitioner asserts this is not a reasonable interpretation of the Medicare statute and therefore is not a permissible construction of 42 U.S.C. § 1395oo(a). This section of the statute allows a provider to seek review of a final determination if:

- the provider is dissatisfied with a *final determination* of the organization serving as its fiscal intermediary as to the amount of total program reimbursement due the provider;
- the amount in controversy is \$10,000 or more; and,
- the provider files a request for a hearing before the Provider Reimbursement Review Board within 180 days after notice of the intermediary's final determination.

42 U.S.C. § 1395oo(a) (emphasis added).

The judiciary is the final authority on issues of statutory construction. Administrative constructions which are found to be contrary to clear congressional intent must be rejected. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984). An agency's construction of a statute is only entitled to deference if it

is reasonable and not in conflict with the intent of Congress. *United States v. Riverside Bayview Homes, Inc.*, 474 U.S. 121, 131 (1985).

The respondent references Section 1395oo(a)(1)(A)(i) of the statute in its brief and correctly notes that this section authorizes the Board to review a fiscal intermediary's "*final determination . . . as to the amount of total program reimbursement due to the provider . . . for the period covered by the provider's cost report.*" Resp't br. to Pet. Cert. 8 (emphasis added). The Respondent then offers a conclusion which petitioner believes is unwarranted:

"That language *plainly refers* to the fiscal intermediary's issuance of the NPR reflecting the total reimbursement due the provider for that fiscal year. It does not readily encompass, however, a denial by the intermediary of a request to alter a prior determination as to whether particular cost items are reimbursable."

Resp't br. to Pet. Cert. 8 (emphasis added).

Petitioner disagrees. That language does not plainly refer to the fiscal intermediary's Notice of Program Reimbursement, it simply refers to a final determination. An agency's interpretation of a regulation is valid only if that interpretation complies with the actual language of the regulation. *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945). The plain language of the Secretary's own regulation does not bar review because 42 C.F.R. § 405.1885(c) reads: "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or

decision." The language says nothing about reviewability; it merely vests the discretion to decide whether or not to reopen. *State of Oregon v. Bowen*, 854 F.2d 346, 349 (9th Cir. 1988). Here, the Secretary's interpretation does not comply with the actual language used in the regulation nor does it comply with the language used in the statute that permits review of a final determination.

The Secretary must agree that the refusal to reopen is a final determination. In fact, in *State of Oregon*, 854 F.2d at 346, the court noted such an admission: "[a]lthough the NPR is often the final determination in question, the fiscal intermediary's refusal to reopen also qualifies as a final determination, a fact the Secretary concedes in his briefs." Since the Secretary has recognized the refusal to reopen is a final determination, this *type* of final determination can only be classified as an exception to the statute which permits providers the opportunity to request review of final determinations *if* the Secretary interprets the language in the statute to mean something other than what it states on its face. In order to block review of this type of final determination, the Secretary interprets the phrase "a final determination" to mean a Notice of Program Reimbursement. This interpretation is unnecessary and uncalled for because the phrase "a final determination" is not ambiguous. The Secretary's interpretation unfairly limits the right to request a review.

Petitioner asserts that the Secretary of Health and Human Services' interpretation of the regulation at issue is contrary to the clear congressional intent. Congress enacted provisions that assure an appeal process will be available for review of final determinations regarding

Medicare reimbursement. The plain language of the statute simply states that a provider that is "dissatisfied with a final determination" may seek review. 42 U.S.C. § 1395oo(a)(1)(A)(i). The Secretary's interpretation of the phrase "a final determination" to mean the Notice of Program Reimbursement is an obvious departure from the plain language used in the statute. The word "interpret" means to explain or tell the meaning of, to translate, elucidate; to construe in light of individual belief, judgment or *interest*. Webster's Collegiate Dictionary (5th ed.) (emphasis added). It is in the Secretary's interest to interpret the phrase "a final determination" in a very limited way in order to cut off the right to review. This is not in keeping with the statutory provision that allows review of a final determination when a provider is dissatisfied. For this reason, the Secretary's interpretation should not be allowed to stand.

In *Chevron*, two questions are raised which must be answered when an agency's construction of a statute it administers is called into question. The first question is whether Congress itself has addressed the matter:

When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency must give effect to the unambiguously expressed intent of Congress.

*Chevron*, 467 U.S. 837, 842-843.

According to the dictates of *Chevron*, if the intent of Congress is clear, that is the end of the matter. Here we have simple language that the Secretary construes as unclear in order to validate an interpretation that is inconsistent with congressional intent. Therefore, the Secretary's construction of the Medicare statute (through her reading of regulation 42 C.F.R. § 405.1885(c) to prohibit review of a final determination) is not entitled to deference. It fails the first test of *Chevron* because there is no need for an interpretation of the unambiguous language.

If however, this Court concludes that interpretation of the language at issue was appropriate, then the analysis under *Chevron* shifts to consider whether the agency's construction of its statute is reasonable. The review for reasonableness must examine whether the agency properly exercised its discretion within the sphere of its delegated authority. *Chevron*, 467 U.S. 837. Petitioner asserts the Secretary's interpretation is not entitled to deference because it also fails the second test set out in *Chevron*:

If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in absence of an administrative interpretation. Rather, if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

*Id.* at 842-843.

Petitioner asserts the Secretary's reading of the statute is not a permissible construction of the statute because it is in conflict with the intent of Congress and with the plain meaning of 42 U.S.C. § 1395oo(a)(1)(A)(i), which allows review of a final determination. Petitioner also contends that the Secretary's interpretation of the statute (which would allow her to cut off all judicial review of refusals to reopen) is inconsistent with the presumption of judicial review, as stated previously in the Petition for Certiorari. Pet. Cert., 9-22 (adopted and incorporated herein by reference).

As noted above, the first step in the *Chevron* analysis is to determine whether Congress has expressed an intent on the question at issue. *Chevron*, 467 U.S. at 842-843. The second step is to determine whether or not the agency's construction of the statute is reasonable. *Id.* Both steps require an understanding of the statute and the congressional intent regarding the question at issue. Congressional intent can appear within specific language in the statute, or it could be apparent in light of the statutory scheme taken as a whole.

Petitioner asserts that other parts of the Medicare statute also support its position that review for a refusal to reopen must be allowed. Any other reading of the statute would render provisions regarding retroactive corrective adjustments meaningless and therefore superfluous which would not be in accordance with the statutory scheme taken as a whole. In support of this argument, petitioner would show the Secretary's interpretation of her regulation is in conflict with another section of the Medicare statute. This was addressed by the court in *State of Oregon*, 854 F.2d 346 where the

question of clear congressional intent regarding the availability of review when there is a refusal to reopen was discussed at length. In that case, the court held the Secretary's claim of unreviewability cannot be supported by the plain language of the Medicare statute, specifically citing the section which, in effect, calls for the reopening process:

the Secretary's claim of unreviewability cannot be supported by the plain language of the section of the Medicare Act authorizing reopening procedures. The statutory authorization of reopening mandates that the regulation should "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. § 1395x(v)(1)(A)(ii) (1982). Nothing in the plain language of this mandate indicates unreviewability.

*Id.* at 349.

Petitioner adopts the position of the court in *State of Oregon* regarding the frustration of congressional intent. In that decision, the Ninth Circuit Court of Appeals correctly observed that the Secretary's regulation frustrated two clear congressional purposes.

First, via section 1395oo(a) Congress intended to give providers a specific means by which to appeal a fiscal intermediary's cost determination . . . thus, the Secretary's regulation, at least as the Secretary now wishes to interpret it, partly eviscerates the congressional intent of providing administrative review of a fiscal intermediary's cost determination because his policy

would allow questions of mistaken cost determination to go unreviewed. Second, because the Secretary would shelter the reopening decision from review, congress' decision to provide a fair method to make retroactive adjustments is impermissibly negated.

*Id.* at 350. See also 42 U.S.C. § 1395x(v)(1)(A)(ii).

The Secretary's position of unreviewability is not reasonable when read in conjunction with the portion of the statute which requires retroactive corrective adjustments to assure reasonable cost for Medicare services are paid. United States Code Title 42 Section 1395x(v)(1)(A)(ii) requires the Secretary to develop regulations to allow retroactive corrective adjustments for payment of the reasonable cost of services:

Such regulations shall . . . provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by methods of determining costs proves to be either inadequate or excessive.

42 U.S.C. § 1395x(v)(1)(A)(ii).

Such regulations do not provide for the making of suitable retroactive corrective adjustments where the Secretary's agents are allowed to refuse to make the corrective adjustments and the Secretary prohibits review of the refusal. If the Secretary's position is accepted as reasonable, then the statutory mandate for the Secretary to develop regulations which *shall* provide for *suitable retroactive corrective adjustments* is useless to providers who seek a corrective adjustment because their reimbursement was inadequate. This makes a provider's resort to 42 C.F.R. § 1885(c), the regulation that allows a request for

reopening futile when, as in this case, a provider's request is denied and there is no review of the denial available. *The right to request justice is meaningless without the power to enforce fair consideration of the request for relief.* If there is no review of a refusal by an intermediary to reopen a final determination, then complete power rests with one party. Not only does this conflict with the statutory mandate that regulations *shall* provide for the making of suitable retroactive corrective adjustments, but it also creates a de facto double standard because the Secretary is more than willing to reopen a cost report to recoup excessive amounts of reimbursement paid to a provider, but is often quite reluctant to reopen a cost report when a provider was underpaid. In this very case, for the cost reporting period at issue, the intermediary reopened the cost report for petitioner's provider 44-7234 (Sneedville, Tennessee office) to recover excessive compensation which was inadvertently paid to a nurse whose license had been revoked by the State of Tennessee. *See* Docket entry no. 7 from the U.S. District Court record, pp. 14-15 and Exhibit B thereto. The intermediary nevertheless steadfastly refused to reopen the very same cost report for the same year, December 31, 1989, to allow additional compensation to the petitioner's owners even though a salary survey created by an intermediary recognized the claimed salary was reasonable. This de facto double standard is in direct conflict with the statutory proclamation that corrective adjustments be made for a provider when the cost paid proves to be *either* inadequate or excessive. 42 U.S.C. § 1395x(v)(1)(A)(ii).

More evidence of the de facto double standard exists in the case law on this subject. Many cases exist where

the Secretary seeks reopening to *recover* reimbursement yet refuses to reopen to allow a provider additional reimbursement. Most convincing, perhaps, is the Secretary's position as noted in the recent decision by this Court on the subject of Medicare reimbursement of Graduate Medical Education costs. The Secretary's concern for the accuracy of payment required reopening of base year cost reports (even beyond the three year time period normally allowed) in order to assure accurate payment. *Regions Hospital v. Shalala*, 118 S.Ct. 909 (1998).

On February 24, 1998, this Court rendered a decision regarding the Secretary's interpretation of the Graduate Medical Education (GME) amendment and her regulation permitting a reaudit of the base year even where the 1984 cost reports were beyond the three year time period. *Id.* In that case, the Court examined the reaudit regulation that permitted the Secretary to reopen a determination by an intermediary, the Board, or the Secretary herself to recoup excessive reimbursement for a given year. *Id.* The GME amendment required the Secretary to determine a hospital's cost for the reporting period that began in 1984. *Id.* The Secretary interpreted this statute as allowing a reaudit of the 1984 cost reporting periods. *Id.* The reaudit rule was considered a reasonable interpretation of the GME amendment primarily based upon the statute's instruction to determine for the 1984 year the "amount recognized as reasonable." *Id.* at 899. This Court emphasized that the reaudit rule brings the base-year calculation in line with "Congress' pervasive instruction for reasonable cost reimbursement". *Id.* at 900. The rule was recognized as a means to "enable the Secretary . . . to carry out her responsibility to reimburse only reasonable

costs, and to prevent payment of uncovered, improperly classified, or excessive costs." *Id.*

It is the responsibility of the Secretary to pay the reasonable cost, i.e., the correct amount of Medicare reimbursement. It is therefore inconsistent for the Secretary to seek reopenings only when Medicare reimbursement is being recouped and to acquiesce in her intermediary's refusal to reopen cost reports when additional Medicare reimbursement is being sought.

In the present case, the respondent took the position that reviewability of denials of requests to reopen presents an important and recurring issue in the administration of the already overburdened Medicare program. Resp't br. to Pet. Cert. 15. Petitioner would point out that a review process will always create some additional administrative work. Nevertheless, the importance of carrying out congressional intent that reasonable cost be paid under the GME amendment created administrative burdens on the Medicare Program by virtue of the reaudit regulation itself. It is disingenuous of the Secretary to have argued that her interpretation of the GME reaudit regulation is reasonable when it adds administrative burden to the program and now voice concern for the administrative burden which review of the refusal to reopen might cause. If the Secretary is recouping Medicare reimbursement she is willing to burden the administrative process, but when a provider requests additional Medicare reimbursement she streamlines the process with her prohibition on administrative review.

It is readily apparent that the Secretary's decisions to reopen cost reports to recoup Medicare reimbursement

will automatically allow a provider the right to an administrative review process because an Amended Notice of Program Reimbursement will be issued once a cost report is reopened to recover Medicare funds. On the other hand, the intermediary's decisions to refuse reopening will not receive the administrative review process under the Secretary's reading of her regulation 42 C.F.R. § 405.1885(c). Providers' reopening requests (which are obviously made for the purpose of obtaining additional reimbursement) do not receive the same level of administrative review. This leaves the reopening process inconsistent between the parties. The Secretary has the power to make a reopening when she seeks to recoup Medicare reimbursement and the power to refuse a reopening request by a provider if additional reimbursement is sought. This inconsistency is evidence of the double standard that exists. This contradiction cannot be construed as a reasonable reading of the Medicare statute.

## **II. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under the Provider Reimbursement Review Board Statute, 42 U.S.C. § 1395oo?**

Petitioner asserts, for all of the reasons stated in the preceding section of this brief, that there is no need for interpretation of the statutory section at issue because the phrase "a final determination" is not ambiguous. In the alternative, even if this Court finds it appropriate to interpret the Medicare statute on this point, the Secretary's interpretation of her regulation is in direct conflict with the language contained in the Medicare statute. Therefore, the Secretary's construction is not entitled to

deference. Instead, the plain meaning of the statute, which allows the provider that is dissatisfied with a final determination to request review of that final determination, should be accepted as controlling authority on this question. United State Code Title 42, Section 1395oo allows providers to seek review of final determinations. This review process must include those final determinations that are refusals to reopen. The Secretary should not be permitted to extinguish the right to the review procedure set forth in the Medicare statute, "for the court, as well as the agency must give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 842-843.

**III. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under the Federal Question Statute, 42 U.S.C. § 1331?**

Petitioner asserts that the Medicare statute, 42 U.S.C. § 1395oo, does provide an appeal process as stated in the preceding sections of this brief. If the Court agrees with this contention as the correct reading of the law, then an avenue of administrative review would be available which might dispense with the need to resort to federal question jurisdiction in order to obtain judicial review a refusal to reopen a final determination. However, even if the petitioner is successful at this juncture and prevails based upon its reading of 42 U.S.C. § 1395oo, the question still remains as to the Sixth Circuit decision that petitioner's claims were not entitled to review at the U.S. District Court level under federal question jurisdiction because the Medicare statute precludes federal question jurisdiction as a basis for review. Pet. App. 12. *See also*

*Your Home Visiting Nurse Services, Inc. v. Secretary of Health and Human Services*, 132 F.3d 1135, n.3 (6th Cir. 1997) (where the court questioned the continuing validity of the amount/methodology distinction referenced in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986)). Petitioner adopts and incorporates by reference its argument presented in the Petition for Certiorari, pages 9-22, regarding the presumption to judicial review under the federal question statute. If petitioner does not convince the Court that 42 U.S.C. § 1395oo provides an avenue for administrative appeal of refusals to reopen, then reliance upon 28 U.S.C. § 1331 must again be proposed as a jurisdictional grant for this situation.

In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 678 (1986), this Court concluded it would be implausible to think that Congress intended there be no forum to adjudicate statutory and constitutional challenges to regulations promulgated by the Secretary. Unfortunately, the Sixth Circuit would not accept petitioner's argument that collateral challenges, not requiring consideration of the merits of a Medicare claim, are outside the scope of the statute. *Your Home Visiting Nurse Services v. Shalala*, 132 F.3d 1135 (6th Cir. 1997); Pet. Cert. 11.

Your Home's argument is foreclosed by *Heckler v. Ringer*, 466 U.S. 602 (1984). In *Ringer*, the Secretary of Health and Human Services issued an administrative ruling that Medicare did not cover certain surgical procedure. Four individual claimants brought a suit challenging the ruling, asserting federal question jurisdiction. The Court held that § 405(h) barred the suit, finding that "the inquiry in determining whether

§ 405(h) bars federal question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." *Id.* at 614-15. The proper test is whether " 'both the standing and the substantive basis for the presentation' of the claims" is the Medicare statute. *Id.* at 615 (quoting *Weinberger v. Salfi*, 422 U.S. 749, 760-61 (1975)).

*Your Home Visiting Nurse Services*, 132 F.3d 1135; Pet. Cert. App. 11-12.

The Sixth Circuit's reliance upon *Heckler v. Ringer*, 466 U.S. 602 (1984) to the exclusion of the more recent decision *Michigan Academy*, 476 U.S. 667, sets the stage for the denial of jurisdiction in U.S. District Courts when providers challenge the Secretary's regulations or procedures which contradict the Medicare statute or constitutional provisions. Petitioner presented two collateral challenges in the proceedings below: the validity of regulation 42 C.F.R. § 1885(c); and the intermediary's failure to abide by 42 C.F.R. § 413.102(b)(2)(i) which requires that owners' compensation be such an amount as would ordinarily be paid by comparable institutions. While it could be argued that the lower courts agreement with the Provider Reimbursement Review Board's refusal to grant jurisdiction to hear this matter essentially addressed the first collateral challenge, neither court addressed the allegation concerning the intermediary's violation of a federal regulation. Petitioner specifically raised this issue. See Docket entry no. 7, U.S. District Court record, plaintiff's brief, 11-12:

The intermediary's refusal to review evidence was *arbitrary and capricious* in that BCBS/SC refused to

review the evidence concerning the previous intermediary's failure to follow the Medicare guidelines which require owners compensation to be " . . . such an amount as would ordinarily be paid for comparable services by comparable institutions." 42 CFR 413.102(b)(2)(i). The refusal to reopen the 1989 cost report to correct this error is a clear *abuse of discretion*. The owners' compensation being paid to YHVNS is *not in accordance with law*. The regulation cited above legally requires payment to owners to be comparable to payment made for comparable services by comparable institutions. Comparing a single home health agency's Administrator's salary to that of a chain operation Administrator's salary is not in accordance with law.

*Id.* (emphasis in original).

Both courts concluded there was no basis for jurisdiction to hear the matter. Since the violation of the Secretary's own regulation was a collateral challenge and would not have addressed the merits of the underlying claim (i.e., the precise amount of allowable owners' compensation), both courts erred in their refusal to grant jurisdiction to hear that collateral challenge. Petitioner believes this is an important point that should be addressed by the Court in this case.

Also of great importance in this matter is petitioner's contention that the lower courts misconstrued the concepts set out in *Heckler v. Ringer*, 466 U.S. 602 where this Court recognized that judicial review of a claim under the Medicare statute is available only after the Secretary of Health and Human Services renders a 'final decision.' "Pursuant to her rulemaking authority the Secretary has

provided that a 'final decision' is rendered on a Medicare claim only after the claimant has pressed the claim through all designated levels of administrative review." *Id.* at 602. Plaintiffs in that case were required to exhaust their administrative remedies before pursuing an action in federal court. In the present case, petitioner attempted to follow the administrative appeal process by requesting review of the denial of the reopening. If the Secretary's reading of 42 C.F.R. § 405.1885(c) is accepted as reasonable, there is no administrative process available to exhaust when there is a denial of a reopening request. That was not the situation in *Heckler v. Ringer*:

Although respondents would clearly prefer an immediate appeal to the District Court rather than the often lengthy administrative review process, exhaustion of administrative remedies is in no sense futile for these respondents, and they, therefore, must adhere to the administrative procedure which Congress has established for adjudicating their Medicare claims.

*Id.* at 619.

The Court notes that in *Weinberger v. Salfi*, the purpose of the exhaustion requirement is to prevent "premature interference with agency processes" and to give the agency a chance "to compile a record which is adequate for judicial review." *Heckler v. Ringer*, 466 U.S. at 619 n. 12 (citing *Weinberger v. Salfi*, 422 U.S. 749, 765 (1975)). These statements by the Court make it obvious that the concept of exhaustion is meant to apply to those situations in which there is an administrative review process to exhaust.

In *Michigan Academy*, 476 U.S. 667, this Court severely restricted the decision of *Heckler v. Ringer* when it upheld jurisdiction under 28 U.S.C. § 1331 to challenge the validity of a regulation authorizing payment. Therefore, to the extent that claims involve matters outside the articulated statutory review process, jurisdiction should be available under § 1331. *Medical Fund-Philadelphia Geriatric Center v. Heckler*, 804 F.2d 33, 38-39 (3rd Cir. 1986). There is a strong presumption that Congress intends judicial review of administrative action. *Abbott Laboratories v. Gardner*, 387 U.S. 136, 140 (1967). That presumption is even stronger for Medicare claims that lack an administrative forum "for it is implausible to think that Congress provided no forum to adjudicate statutory and constitutional challenges to the Secretary's policies although it provided review by Medicare carriers of claims over amounts Congress characterized as 'trivial.'" *Michigan Academy*, 476 U.S. at 677.

In the present case, the Secretary reads her regulation to preclude administrative review and also relies upon § 405(h) to preclude judicial review under federal question jurisdiction. This would allow a host of final determinations to remain completely insulated from judicial review, an extreme contradiction to the well-established presumption of judicial review of agency action. Therefore, § 405(h) should not be a bar to federal question jurisdiction for collateral claims.

**IV. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under Mandamus Jurisdiction, 42 U.S.C. § 1361?**

Petitioner believes the Medicare statute provides an administrative review process, but if the Court does not accept this view, then the alternative of federal question jurisdiction is offered as an appropriate jurisdictional grant for judicial review of final agency action. If this Court finds federal question jurisdiction is precluded by § 405(h) of the Medicare statute, then the petitioner would rely upon 28 U.S.C. § 1361 for jurisdiction in this matter. This Court has not yet ruled upon the question of whether the third sentence of § 405(h) is a bar to mandamus jurisdiction in Social Security cases:

Assuming without deciding that the third sentence of § 405(h) does not foreclose mandamus jurisdiction in all Social Security cases, . . . the District Court did not err in dismissing respondents' complaint here because it is clear that no writ of mandamus could properly issue in this case. The common law writ of mandamus, as codified in 28 U.S.C. § 1361, is intended to provide a remedy for a plaintiff only if he has exhausted all other avenues of relief and only if the defendant owes him a clear nondiscretionary duty. See *Kerr v. United States District Court*, 426 U.S. 394, 402-403 (1976) (discussing 28 U.S.C. § 1651); *United States ex rel. Girard Trust Co. v. Helvering*, 301 U.S. 540, 543-544 (1937).

*Heckler v. Ringer*, 466 U.S. at 616-617.

Many Courts of Appeals that have considered the question have ruled that mandamus remains available under the Social Security Act. *Lopez v. Heckler*, 725 F.2d

1489 at 1507-8 (9th Cir.), vacated on other grounds, 469 U.S. 1082 (1984); *Ganem v. Heckler*, 746 F.2d 844, 850 (DC Cir. 1984); *Belles v. Schweiker*, 720 F.2d 509, 512-513 (8th Cir. 1983); *Kuehnor v. Schweiker*, 717 F.2d 813, 819 (3rd Cir. 1983), vacated on other grounds, 469 U.S. 977 (1984); *Ellis v. Blum*, 643 F.2d 68, 78 (2nd Cir. 1981). These cases find mandamus jurisdiction appropriate for procedural challenges where the court will not need to address substantive rights. In the present case, the petitioner challenged the intermediary's failure to follow regulations regarding the appropriate procedure to be used to determine the reasonableness of owners' compensation. 42 C.F.R. § 413.102(b)(2)(i).

There are two questions that must be answered regarding mandamus jurisdiction. First, if the plaintiff has exhausted all other avenues of relief, and second, if there is a nondiscretionary duty involved. The Sixth Circuit spoke to the question of exhaustion in its decision on the present case when it found that the district court's holding with respect to exhaustion was incorrect. *Your Home Visiting Nurse Services*, 132 F.3d 1135; Pet. App. 13. The Sixth Circuit recognized that petitioner had exhausted all available remedies with respect to its claim that the intermediary, improperly denied its request to reopen. Unfortunately for petitioner, the court went on to hold that the duty to reopen was discretionary in nature and therefore would not have triggered mandamus jurisdiction. *Id.*; see also Pet. App. 15. Petitioner disagrees with two aspects of the ruling regarding mandamus.

Petitioner asserts that the Secretary owed it two nondiscretionary duties and therefore mandamus should provide a basis for jurisdiction to permit judicial

enforcement of those duties. First and foremost, is the duty to determine reasonable cost in accordance with regulations governing that cost, a mandatory duty which was ignored by the intermediary. United State Code Title 42, Section 1395x(v)(1)(A) (emphasis added) states in pertinent part "[t]he reasonable cost of any services shall be the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and *shall be determined in accordance with regulations* establishing the method or methods to be used." The Secretary's agent, the intermediary, violated the Secretary's own regulations because it did not pay the owners of petitioner's home health agency in accordance with regulation 42 C.F.R. § 413.102(b)(2)(i) which requires that owners compensation be "such an amount as would ordinarily be paid for comparable services by comparable institutions." The agency must abide by its own regulations. *United States v. Nixon*, 418 U.S. 683, 694-696 (1974); *Service v. Dulles*, 354 U.S. 363, 388 (1957); *Morton v. Ruiz*, 415 U.S. 199, 235 (1974). Because the Secretary is ultimately responsible for the actions of its agent, the intermediary, the Secretary is therefore responsible for the intermediary's failure to perform this nondiscretionary duty. Once the failure to pay the petitioner's owners in accordance with the applicable regulation was discovered, the request to reopen the cost reports was made, the intermediary refused the request, appeal to the Provider Reimbursement Review Board was sought. The refusal of the Board to accept jurisdiction led petitioner to resort to the judicial process where review was requested under alternative theories, one of which was mandamus. The Sixth Circuit found the decision

concerning the refusal to reopen to be discretionary but failed to address the underlying nondiscretionary duty that is the heart of the matter. If the refusal to reopen is considered discretionary, then the Secretary can violate her regulations at any time, fail to perform nondiscretionary duties, and then allow her intermediaries to exercise their discretion NOT to reopen with impunity. This creates a situation where the Secretary's agents, the insurance companies hired as fiscal intermediaries, can refuse to perform nondiscretionary functions, can violate federal regulations and yet, their refusal to abide by law will be totally insulated from corrective action. No matter what the nature of the duty is, or how blatant the refusal to perform the duty might be, it would be unreviewable under the Secretary's reading of the reopening procedure as a discretionary function.

Secondly, petitioner asserts that the Secretary is also incorrect in her interpretation of the statute as permitting her to characterize the reopening process as a discretionary function. The Secretary's reopening regulation contains both discretionary and mandatory language depending upon the circumstances. See 42 C.F.R. § 405.1885(a) (which states that a determination *may* be reopened by the intermediary or panel of hearing officers, the Board, the Secretary, or on motion of the provider, compared with paragraph (b) which states that a determination *shall* be reopened if HCFA notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations or general instructions issued by HCFA); See also 42 C.F.R. § 405.1885(d) (which states that a decision *shall* be reopened and revised at any time if it is established that

such determination or decision was procured by fraud or similar fault of any party to the determination or decision. As shown by these excerpts, the provider is limited in its right to receive a reopening). By use of the word 'may' (the discretionary language in 42 C.F.R. § 405.1885(a) which applies to the provider's motion for reopening) a discretionary situation is created in the Secretary's regulation. This discretionary situation was not created by the statute.

The statute regarding the duty to make regulations which allow for the corrective retroactive adjustments was drafted with mandatory terms. See 42 U.S.C. § 1395x(v)(1)(A) (emphasis added) (where compulsory language is used: "Such regulations *shall* . . . (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."). Petitioner argues that the duty to make corrective adjustments is not discretionary in the Medicare statute and therefore the reopening regulation, insofar as it purports to allow the Secretary's agents discretion for making such corrective adjustments, is not a permissible interpretation of the plain language in the Medicare statute. Since the corrective adjustment to bring the petitioner's owners' compensation in line with its competitors is a mandatory duty in accordance with the regulation at 42 C.F.R. § 413.102(b)(2)(i) and the Medicare statute noted above requiring regulations for the corrective adjustments is also mandatory in nature, the U.S. District Court and the Sixth Circuit Court of Appeals erred in failing to allow petitioner's case to proceed with

judicial review. District courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff. 28 U.S.C. § 1361. If a provider has new and material evidence or the prior determination is found to be inconsistent with law regulations or rulings, then there is a valid basis for reopening and the court has federal question and mandamus jurisdiction to review the refusal to reopen. *Memorial Hospital v. Sullivan*, 779 F.Supp. 1410, 1412-13 (D.D.C. 1991).

Therefore, if this Court accepts petitioner's view that the duty to reopen to make corrective adjustments is not discretionary, then the judiciary would be an appropriate forum for review of a refusal to reopen. If the Court accepts the Secretary's view that reopening is a discretionary determination, the petitioner would still rely upon mandamus as available to a provider, such as petitioner, where it can be shown that the intermediary failed to perform a mandatory duty. In this case, the violation of 42 C.F.R. § 413.102 is, in and of itself, the failure to perform a nondiscretionary duty. As a result, mandamus was an appropriate basis for jurisdiction to address the breach of a nondiscretionary duty.

**V. Is there jurisdiction for review of a refusal to reopen a Medicare provider's cost report under the Administrative Procedure Act 5 U.S.C. § 706?**

Under the Administrative Procedure Act (APA) the Secretary's decisions regarding provider's claims for Medicare reimbursement shall be set aside if the decision

is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence or contrary to law. 5 U.S.C. § 706(2)(A); *Hennepin County Medical Center v. Shalala*, 81 F.3d 743, 748 (8th Cir. 1996). In *State of Oregon* the Ninth Circuit Court of Appeals aptly noted that the Secretary's promulgation of section 1885(c) fails to make a distinction between the discretion to decide an issue and the review of an administrative body's exercise of its discretion:

Thus, even though the Secretary has disqualified the Board by virtue of section 1885(c) from deciding whether or not the fiscal intermediary should reopen, the Board has not been disqualified from deciding whether the fiscal intermediary abused its discretion by refusing to reopen the determination. See 5 *Davis, Administrative Law Treatise*, (2d ed. 1984) § 28:10, at 311. See also *Dunlop v. Bachowski*, 421 U.S. 560, 571-73 (1975) (allowed review for abuse of discretion, even though courts could not decide the issue in question).

*State of Oregon*, 854 F.2d at 350.

The question of whether there was an abuse of discretion should be addressed by the Board when a final determination regarding refusal to reopen is appealed to that forum. If the refusal to reopen was arbitrary and capricious, it should be reversed. This Court has recognized the weight to be given to the agency's views will depend upon the facts of individual cases. *Good Samaritan Hospital, et al. v. Shalala*, 508 U.S. 402, 417 (1993). Where the statute entrusts the Secretary with the responsibility for implementing a provision by regulation, the court's review is limited to determining whether the regulations

exceed the Secretary's authority and whether they are arbitrary and capricious. *Heckler v. Campbell*, 461 U.S. 458, 466 (1983). In *Good Samaritan Hospital*, the Secretary's restrictive reading of the clause of the statute at issue was considered plausible and the Court felt that it closely fit the design of the statute as a whole and did not exceed her statutory authority. *Id.* In the present case, it is difficult to imagine how the Secretary could support her reading of the statute as fitting the design of the Administrative Procedure Act (APA) which allows for review of final determinations while the Secretary would prohibit such review.

It is worthwhile to note that the Board has found abuse of discretion in a refusal to reopen as recently as June 2, 1998. See *Mary Imogene Bassett Hospital v. Blue Cross and Blue Shield Association/Empire Blue Cross and Blue Shield*, PRRB decision 98-D58, <http://www.hcfa.gov/regs/98d58.htm>. In *Mary Imogene Bassett*, the Board found the intermediary's refusal to reopen was an abuse of discretion because the intermediary had employed an unapproved method to calculate Medicare reimbursement which was not in accordance with existing laws and regulations and which constituted a clear and obvious error. *Id.*

If this Court does not establish a provider's right to obtain review of a refusal to reopen, intermediaries may abuse their discretion and remain unchallenged. The magnitude of the loss of reimbursement which can result from a refusal to reopen may be substantial as it was in the case of *Ashland Regional Medical Center v. Shalala*, 1998 WL 156972 (E.D.Pa. 1998). The court in *Ashland* recognized the intermediary's refusal to reopen the cost

reports was "harsh" and would result in a loss to the hospital of over five million dollars. Unfortunately, the court held the intermediary's refusal to reopen was entirely within its discretion and found the Board's decision that it lacked jurisdiction was supported by substantial evidence. *Id.* at \*6. In reaching this conclusion, the court made some interesting observations. The case concerned a hospital that had failed to file its cost report correctly. Because the hospital had less than 100 beds available, it would have qualified for an additional five million dollars, if it had properly reported this information to the intermediary. *Id.* at \*3. The hospital requested that its intermediary reopen the cost reports at issue. The intermediary refused to reopen and the hospital appealed the decision to the Board. The Board dismissed the hearing request citing lack of jurisdiction. Appeal to the U.S. District Court was made. When the U.S. District Court for the Eastern District of Pennsylvania reviewed the case, the court focused upon the fact that the hospital had made the initial mistake:

Indeed, there are often times in life that we are only given one bite at the apple and are forced to live with our mistakes. While this may sometimes seem unfair, life is not always fair. Thus, we refuse to hold that the agency's interpretation is unreasonable simply because it is strict and unforgiving. While requiring Ashland to live with its mistakes is indeed harsh (in this case a simple reporting error will cost the hospital over five million dollars), we cannot say that it is unjust.

*Id.* at \*7.

Compare the Secretary's refusal to reopen to correct this mistake which would have increased the provider's reimbursement by five million dollars to the Secretary's willingness to reopen and reaudit the base year cost reports in *Regions Hospital* in order to reduce the allowable amount of reimbursement by five million dollars. *Regions Hospital*, 118 S.Ct. at 909. If the court's reasoning in *Ashland* were applied in *Regions Hospital*, then the intermediary's mistake in the original NPR would have gone uncorrected. The intermediary would have been limited to one bite of the apple. This is another example of the de facto double standard referenced earlier in this brief. The Secretary is simply not being fair. Petitioner does not believe Congress intended that Medicare providers to be treated unfairly in this harsh and inequitable fashion.

The court in *Ashland* placed great emphasis upon the fact that the mistake was made by the provider instead of focusing more precisely upon the review of the Secretary's reopening regulation. The court's discussion effectively accepted the intermediary's refusal to reopen the cost report as reasonable because the provider's mistake caused the situation in the first place. In doing so, the court virtually makes the decision about the reasonableness of the intermediary's refusal to reopen the cost report while refusing to accept jurisdiction to decide that issue. *Ashland Regional Medical Center*, 1998 WL 156972 \*6. In other words, the court looked at the facts and essentially found the refusal to reopen justifiable as reasonable where the provider made the mistake and later sought correction of its own error. Further discussion by the court about situations in which the refusal to reopen

might be an abuse of discretion leads petitioner to believe that court might have ruled differently had petitioner's case been before it. The following excerpt is revealing on this point:

Plaintiff also points out that Defendant's interpretation conflicts with the regulatory provision mandating reopenings based on fraud . . . . However the case before this court does not involve fraud; it involves Plaintiff's own mistake. Thus while Plaintiff makes a strong argument that the Board's refusal to assert jurisdiction over an intermediary's refusal to reopen a case when that intermediary is involved in fraud may be unreasonable, that is not the case before the court today. We will therefore refrain from deciding the hypothetical case proposed by the Plaintiff until such a case is actually before this court.

*Id.* at \*7.

Petitioner must emphasize that it did not make a mistake on the cost reports at issue in the present case. To the contrary, it was the wrongful conduct of the intermediary which was not discovered by petitioner until long after the initial Notice of Program Reimbursement letters had been issued which led to petitioner's request to reopen. If the intermediary had used the appropriate salary survey for home health agency administrators for chain operations which were in the same geographical area as the petitioner's home health agencies (as required by 42 C.F.R. § 413.102(b)(2)(i)) no audit adjustment to decrease the petitioner's owners' compensation would have been made in the first place. It was the error of the intermediary which caused the problem. The error was

brought to the attention of the intermediary when the request for reopening was made and yet, the intermediary refused to correct its own mistake. No justification has been offered for the refusal to correct this error. "When action is taken by the Secretary it must be such as to enable a reviewing court to decide with some measure of confidence whether or not the discretion, which still remains in the Secretary, has been exercised in a manner that is neither arbitrary or capricious . . . . It is necessary for [him] to delineate and make explicit the basis upon which discretionary action is taken." *Dunlop v. Bachowski*, 421 U.S. 560, 573 (quoting *DeVito v. Shultz*, 300 F.Supp. 381, 383 (D.D.C. 1969)).

The petitioner requested reopening on the basis of new evidence, information that was discovered revealed that its owners were being paid less than other owners within the same geographical area. (Joint App. \_\_\_) The intermediary's refusal to reopen did not address the fact that petitioners owners compensation had not been considered in line with comparable agencies within the same geographical area. Nor did the intermediary's refusal to reopen give substantive explanations to support the decision. Instead, three conclusions were stated: (1) The manner in which the home office cost statement was filed was not inconsistent with the law, regulations and rulings or general instructions. (2) A clear and obvious error was not made when these cost reports were filed. (3) And, new and material evidence has not been presented to establish the compensation claimed was inappropriate. Pet. App. 36-37. As to the first conclusion, the intermediary is correct in stating that a reasonable amount of owners compensation was *claimed* on the home office cost

report. The problem is, the amount claimed was not allowed. As to the second conclusion, though it is true that a clear and obvious error was not made when these cost reports were *filed*, the intermediary made a clear and obvious error when the owners' compensation was reduced based upon comparisons to individual home health agencies instead of chain operations. Finally, the third conclusion states that new and material evidence was not presented to establish that the compensation claimed was inappropriate. The petitioner offered new and material evidence that the *reduction to compensation* was inappropriate.

Rather than address the problem presented, the intermediary ignored the basis for the request for reopening. This conduct was in total disregard of the allegations raised regarding the violation of a federal regulation which requires that owners' compensation be "such an amount as would ordinarily be paid for comparable services by comparable institutions." This is a case where the intermediary perpetuated its own mistake.

In *Ashland*, the court recognized that the Board's refusal to assert jurisdiction over an intermediary's refusal to reopen might be unreasonable in circumstances where an intermediary is involved in fraud. (The regulation contains the phrase 'fraud or similar fault'. 42 C.F.R. § 405.1885(d). Unfortunately, the Board may not be able to exercise jurisdiction even if fraud or similar faults were alleged. The Board is required to "make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary." 42 U.S.C. § 1395oo(e). Since the Board is required to act consistent

with the regulations, which are promulgated and interpreted by the Secretary and she reads 42 C.F.R. § 405.1885(c) to mean there is no review of a refusal to reopen (except for providers located in the Ninth Circuit), it remains uncertain whether the Board could accept jurisdiction of a case even if the most blatant act of fraud or similar fault were shown to exist. It is this tremendous potential for extreme abuse of discretion which cannot be corrected through the review process that makes the Secretary's position so incredibly unreasonable. There are definitely times when the Secretary's actions are considered arbitrary and capricious, an abuse of discretion and not in accordance with law. See *Loma Linda Community Hospital v. Shalala*, 907 F.Supp. 1399 (C.D.Cal. 1995). The problem with the Secretary's reading of 42 C.F.R. § 405.1885(c) is that it precludes review of every decision which refuses to reopen a cost report and therefore insulates from review even the most abhorrent abuse of discretion. This particular danger was addressed by this Court. See *Interstate Commerce Commission v. Brotherhood of Locomotive Engineers*, 482 U.S. 270 (1987). "If review of a denial to reopen for new evidence or change in circumstance is unavailable, the petitioner will have been deprived of all opportunity for judicial consideration – even on a 'clearest abuse of discretion' basis – of facts which, through no fault of his own, the original proceeding did not contain." *Id.* at 270. As evidenced by the three sentences which make up the refusal to reopen in this case, there is a need for a well reasoned decision when there is a refusal to reopen a final determination. Once such a decision is rendered, there must be a forum with the authority to review that decision and to set it aside if

the decision is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence or contrary to law. 5 U.S.C. § 706(2)(A). Therefore, jurisdiction under the APA for review of the intermediary's refusal to reopen should be available.

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### CONCLUSION

The Secretary's reading of the Medicare statute as evidenced by her interpretation of 42 C.F.R. § 405.1885(c) is not a permissible construction of the statute because it is in conflict with the intent of Congress and with the plain meaning of 42 U.S.C. § 1395oo, which allows review of a final determination. Therefore, petitioner requests a **ruling** from this Court declaring 42 U.S.C. § 1395oo is appropriate authority for the review of a final determination, including a final determination which is a refusal to reopen, and an **Order** remanding the case back to the Provider Reimbursement Review Board for a determination as to the appropriateness of the intermediary's refusal to reopen the cost reports at issue in this matter.

If the Court is not convinced that 42 U.S.C. § 1395oo provides an avenue for administrative appeal of refusals to reopen, then reliance upon 28 U.S.C. § 1331 must again be proposed as an alternative for jurisdiction. Even if the petitioner is successful at this juncture and wins the case based upon its reading of 42 U.S.C. § 1395oo, the question remains as to the Sixth Circuit decision that petitioner's claims were not entitled to review at the U.S. District Court level under federal question jurisdiction because the Medicare statute, 42 U.S.C. § 405(h), precludes federal

question jurisdiction as a basis for review. Therefore, if this Court accepts the Secretary's position that 42 U.S.C. § 1395oo does not provide for administrative review of a refusal to reopen, then petitioner seeks a **ruling** from this Court stating that resort to 28 U.S.C. § 1331 is appropriate for judicial review of a refusal to reopen and an **Order** remanding the case back to U.S. District Court for the Eastern District of Tennessee for review of the intermediary's refusal to reopen the cost reports at issue in this matter. In addition thereto, if this Court finds that 42 U.S.C. § 1395oo does provide for administrative review of a refusal to reopen, the petitioner nevertheless seeks a **ruling** from this Court which recognizes that 28 U.S.C. § 1331 remains available for challenges to the extent that claims involve matters outside the articulated statutory review process and validates the continuing force of the decision stated in *Michigan Academy*, 476 U.S. 667.

If this Court finds federal question jurisdiction is precluded by 42 U.S.C. § 405(h) of the Medicare statute, then the petitioner would rely upon 28 U.S.C. § 1361 for jurisdiction in this matter. Petitioner therefore requests a **ruling** by this Court that the third sentence of § 405(h) is not a bar to mandamus jurisdiction in Social Security cases, and an **Order** remanding the case back to the U.S. District Court for the Eastern District of Tennessee for judicial review of the intermediary's refusal to reopen the cost reports at issue in this matter, which petitioner asserts is a nondiscretionary duty, and in addition thereto, or in the alternative, for judicial review of the intermediary's refusal to pay petitioner's owners' compensation in accordance with regulation 42 C.F.R.

§ 413.102, which petitioner also asserts is a nondiscretionary duty.

Finally, petitioner seeks a ruling from this Court which states that the Administrative Procedure Act requires that decisions regarding provider's claims for Medicare reimbursement shall be set aside if the decision is arbitrary, capricious, an abuse of discretion, unsupported by substantial evidence or contrary to law, 5 U.S.C. § 706(2)(A), which includes decisions regarding refusals to reopen and therefore, the APA is an appropriate basis for review of the intermediary's refusal to reopen, and an Order remanding the case back to the U.S. District Court for the Eastern District of Tennessee for judicial review of the intermediary's refusal to reopen the cost reports at issue in this matter.

Respectfully submitted,

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## APPENDIX A

### 42 C.F.R. § 413.102: Compensation of Owners

(a) *Principles.* A reasonable allowance of compensation for services of owners is an allowable cost, provided the necessary services are actually performed in a necessary function.

(b) *Definitions.* (1) *Compensation.* Compensation means the total benefit received by the owner for the services he renders to the institution. It includes:

(i) Salary amounts paid for managerial, administrative, professional, and other services.

(ii) Amounts paid by the institution for the personal benefit of the proprietor.

(iii) The cost of assets and services which the proprietor receives from the institution.

(iv) Deferred compensation.

(2) *Reasonableness.* Reasonableness requires that compensation allowance:

(i) Be such an amount as would ordinarily be paid for comparable services by comparable institutions.

(ii) Depends upon the facts and circumstances of each case.

(3) *Necessary.* Necessary requires that the function:

(i) Be such that had the owner not rendered the services, the institution would have had to employ another person to perform the services.

(ii) Be pertinent to the operation and sound conduct of the institution.

(c) *Application.* (1) Owners of provider organizations often render services as managers, administrators, or in other capacities. In such cases, it is equitable that reasonable compensation for the services rendered be an allowable cost. To do otherwise would disadvantage such owners in comparison with corporate providers or providers employing persons to perform similar services.

(2) Ordinarily, compensation paid to proprietors is a distribution of profits. However, where a proprietor renders necessary services for the institution, the institution is in effect employing his services, and a reasonable compensation for these services is an allowable cost. In corporate providers, the salaries of owners who are also employees are subject to the same requirements of reasonableness. Where the services are rendered on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Reasonableness of compensation may be determined by reference to, or in comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.

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SEP 18 1998

No. 97-1489

**In the Supreme Court of the United States**

OCTOBER TERM, 1997

**YOUR HOME VISITING NURSE SERVICES, INC.,**  
**PETITIONER**

*v.*

**DONNA E. SHALALA, SECRETARY OF**  
**HEALTH AND HUMAN SERVICES**

**ON WRIT OF CERTIORARI TO**  
**THE UNITED STATES COURT OF APPEALS**  
**FOR THE SIXTH CIRCUIT**

**BRIEF FOR THE RESPONDENT**

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### **QUESTION PRESENTED**

Whether a fiscal intermediary's denial of a Medicare provider's request to reopen an annual reimbursement determination under Part A of the Medicare program is subject to administrative and judicial review under 42 U.S.C. 1395oo and, if not, whether the denial is subject to judicial review under 28 U.S.C. 1331, 28 U.S.C. 1361, or the Administrative Procedure Act, 5 U.S.C. 706.

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# In the Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-1489

YOUR HOME VISITING NURSE SERVICES, INC.,  
PETITIONER

*v.*

DONNA E. SHALALA, SECRETARY OF  
HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO  
THE UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT

**BRIEF FOR THE RESPONDENT**

## OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-15) is reported at 132 F.3d 1135. The opinion of the district court (Pet. App. 17-33) is unreported. The decision of the Provider Reimbursement Review Board (J.A. 14-24) is unreported.

## JURISDICTION

The judgment of the court of appeals (Pet. App. 38-39) was entered on December 22, 1997. The petition for a writ of certiorari was filed on March 11, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

## STATUTORY AND REGULATORY PROVISIONS INVOLVED

The provisions of 5 U.S.C. 706, 28 U.S.C. 1331 and 1361, and 42 U.S.C. 405(h), 1395x(v)(1)(A), and 1395oo are set forth at Pet. App. 40-50. The provisions of 42 C.F.R. 405.1885 are set forth at Pet. App. 51-52.

### STATEMENT

1. In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered inpatient hospital and related post-hospital services, including certain home health services that are provided to an individual on a visiting basis at the individual's place of residence. 42 U.S.C. 1395x(m).<sup>1</sup> When patient beneficiaries receive covered home health services, the Secretary reimburses the providers of those services under the Medicare Act and the Secretary's implementing regulations. 42 U.S.C. 1395f(b)(1), 1395x(v)(1)(A).

A provider's total allowable Medicare payment is based on a "cost report" that it must prepare after the close of its fiscal year. 42 C.F.R. 405.1801(b), 413.24(f). The cost report is filed with a "fiscal intermediary," generally a private insurance company that is nominated by a group or association of providers and determines the amount of payments to be reimbursed by the Secretary pursuant to an agreement with the Secretary. 42 U.S.C. 1395h. The cost report shows the provider's costs and the percentage of those costs allocated to Medicare services. 42 C.F.R. 413.20(b), 413.24(f). The

<sup>1</sup> Part B is a voluntary supplementary insurance program covering physicians' charges and other medical services. 42 U.S.C. 1395k, 1395l, 1395x(s). This case arises under the Part A program. See pp. 39-40, *infra*.

intermediary analyzes the cost report, audits it if necessary, and issues the provider a written "notice of amount of program reimbursement" (NPR) containing the final determination of the total amount due the provider for Medicare services during the reporting period. 42 C.F.R. 405.1803. See *Regions Hosp. v. Shalala*, 118 S. Ct. 909, 913 (1998). During the provider's fiscal year, the Secretary makes advance interim payments reflecting the provider's pre-audited estimated costs of anticipated services. 42 U.S.C. 1395g(a); 42 C.F.R. 413.60. As a result, the NPR reflects any adjustments that are necessary to reconcile the aggregate amount of interim payments paid to the provider during the course of the fiscal year with the provider's reimbursable costs as reflected in the NPR. 42 U.S.C. 1395x(v)(1)(A)(ii); 42 C.F.R. 405.1803(c), 413.64(e)-(f); *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402 (1993).

Congress has specified in the Medicare Act itself a comprehensive scheme for administrative and judicial review of "a final determination of [a fiscal intermediary] as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under [Medicare] for the period covered by [the provider's cost] report." 42 U.S.C. 1395oo(a)(1)(A)(i).<sup>2</sup> A "dissatisfied" provider may obtain a hearing before the Provider Reimbursement Review Board (PRRB), whose members are appointed by the Secretary, if the amount in controversy equals or exceeds \$10,000 (or \$50,000 for group appeals) and the provider requests a hearing "within 180 days after notice of the intermediary's final determination." 42 U.S.C. 1395oo(a)(1)(A)(i), (a)(2),

<sup>2</sup> Congress also has established administrative and judicial review procedures for claimants who are denied Medicare benefits under Part A or B of the Medicare program. See 42 U.S.C. 1395ff (incorporating procedures under 42 U.S.C. 405(b) and (g)); see also pp. 26-27, 38-41, *infra*.

(a)(3), (b), and (h); 42 C.F.R. 405.1835, 405.1837, 405.1845(a). See *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 403-404 (1988).

The Board has authority to "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to [the] cost report and to make any other revisions on matters covered by such cost report \* \* \* even though such matters were not considered by the intermediary in making [its] final determination." 42 U.S.C. 139500(d). The Board's decision may be reversed, affirmed, or modified by the Secretary within 60 days after the provider is notified of the Board's decision. Unless reviewed by the Secretary, the Board's decision is final, and is subject to judicial review in federal district court if an action is brought within 60 days. 42 U.S.C. 139500(f)(1); 42 C.F.R. 405.1877.<sup>3</sup>

The Secretary has promulgated regulations governing "[r]eopening[s]" of Medicare reimbursement determinations. 42 C.F.R. 405.1885. Under those regulations, a determination by the intermediary may be reopened within three years (or at any time in the case of fraud) with respect to specific "findings on matters at issue in [the intermediary's] determination," by motion of either the intermediary or the provider affected by the intermediary's determination. 42 C.F.R. 405.1885(a) and (d); see *Regions Hosp.*, 118 S. Ct. at

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<sup>3</sup> Providers may also obtain expedited judicial review of any action taken by a fiscal intermediary "which involves a question of law or regulations relevant to the matters in controversy," if the PRRB has jurisdiction and determines that "it is without authority to decide the question" or fails to make a timely determination of its authority to decide the question. 42 U.S.C. 139500(f)(1); 42 C.F.R. 405.1842(b). The Board is authorized by regulation to deny expedited judicial review if it finds that the issue on which review is sought is intertwined with disputed factual or legal issues that it is authorized to decide. 42 C.F.R. 405.1842(g)(2).

913.<sup>4</sup> An intermediary's determination "shall be reopened and revised by the intermediary" if the Health Care Financing Administration (HCFA) notifies the intermediary that the determination "is inconsistent with the applicable law, regulations, or general instructions issued by [HCFA]." 42 C.F.R. 405.1885(b). The Secretary's Provider Reimbursement Manual (PRM) also states that "[w]hether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions" of the Secretary. PRM § 2931.2.

The Secretary's regulations provide that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R. 405.1885(c). The PRM explains that "[a] provider has no right to a hearing on a finding by an intermediary \* \* \* that a reopening \* \* \* of a determination \* \* \* is not warranted." PRM § 2932.1. The PRM similarly states that "[a] refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 C.F.R. § 405.1885(c)." PRM § 2926, App. A, ¶ B.4. In the event the intermediary does reopen the prior determination, however, a provider may appeal to the Board any adjustments made by the intermediary in a revised NPR, if the amount in controversy and filing requirements are satisfied. 42 C.F.R. 405.1889. The Board's final decision concerning the revised NPR would then be subject to judicial review under 42 U.S.C. 139500(f)(1).

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<sup>4</sup> The regulations also authorize the Board and the Secretary to reopen their respective decisions. 42 C.F.R. 405.1885(a).

Finally, the second and third sentences of Section 205(h) of Title II of the Social Security Act, 42 U.S.C. 405(h), made applicable to the Medicare Act by 42 U.S.C. 1395ii, provide:

No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. 405(h).

2. Petitioner provides home health care services to Medicare beneficiaries and is reimbursed on a reasonable cost basis. Pet. App. 2; see 42 U.S.C. 1395f(b)(1)(A). For its 1989 fiscal year, petitioner submitted four cost reports for its four constituent home health agencies. Pet. App. 3. The reports included requests for payment for certain compensation to its owners as an allowable cost reimbursable under the Medicare program. See 42 C.F.R. 413.102(a). Petitioner prepared those cost reports after receiving the fiscal intermediary's NPR for fiscal year 1987, which had disallowed a portion of the provider's claimed owners' compensation costs. As a result, petitioner did not claim reimbursement for \$48,890 in owners' compensation on its 1989 cost reports, and attached a schedule of "[p]rotested" amounts. J.A. 32, 50, 52; cf. *Bethesda Hosp. Ass'n*, 485 U.S. at 401-402. On March 29, 1991, petitioner's fiscal intermediary issued four NPRs that determined the total amount of program reimbursement due to petitioner; the NPRs did not include payments for the protested amounts. J.A. 34-56. The NPRs notified petitioner of its right under Section 1395oo(a) to seek review of the intermediary's determination within 180 days of the notice. J.A. 37, 41, 45, 49. Petitioner did not appeal any of the four NPRs to the PRRB within the statutory time

period. Pet. 23; Pet. App. 3. By contrast, petitioner did administratively appeal the intermediary's determination as to allowable owners' compensation costs for fiscal years 1987, 1990, 1991, 1992, 1993, and 1994. Pet. 23.

On March 28, 1994, less than three years from the date of the issuance of the NPRs for petitioner's fiscal year 1989, petitioner requested its intermediary to reopen the final reimbursement determinations for 1989 for petitioner's four agencies under the Secretary's reopening regulations. J.A. 31-34. Petitioner claimed that during the course of appealing the intermediary's denial of certain owners' compensation costs for fiscal years other than 1989, petitioner discovered that the intermediary had failed to compare petitioner's costs to salary data for officers of home health agency chains, and that the intermediary accordingly should "recompute" the provider's allowable owners' compensation costs. J.A. 32. On April 21, 1994, the intermediary denied the request for reopening, finding that the cost reports were "not inconsistent with the law, regulations and rulings or general instructions"; that a "clear and obvious error was not made when these cost reports were filed"; and that "new and material evidence has not been presented to establish that the compensation claimed was inappropriate." J.A. 28-29. On October 14, 1994, petitioner sought to appeal the intermediary's denial to the PRRB. J.A. 25-27. On January 10, 1995, the PRRB dismissed petitioner's appeal on the ground that, under 42 C.F.R. 405.1885(c), it lacked jurisdiction to review the reopening denial. J.A. 15. The PRRB concluded that, because "the Intermediary was the administrative body that rendered the last determination [on petitioner's reimbursement], it is the Intermediary's decision whether or not to reopen the cost report." *Ibid.*

3. Petitioner filed suit in the United States District Court for the Eastern District of Tennessee, requesting that the court order the PRRB to review the intermediary's de-

nial of the request to reopen its final determinations for petitioner's 1989 fiscal year or, in the alternative, order the intermediary to reopen petitioner's NPRs to make additional payments for the claimed costs regarding owners' compensation. J.A. 61. The district court dismissed petitioner's complaint on the ground that the PRRB does not have jurisdiction under 42 U.S.C. 139500(a) over an intermediary's denial of a request to reopen a provider's NPR. Pet. App. 16-33. The court reasoned that "the Secretary's determination as reflected in the Medicare regulations and Provider Reimbursement Manual that denials of reopening requests are unreviewable is a reasonable interpretation of the Medicare statute." *Id.* at 26. The court also rejected petitioner's alternative contention that the court could review the intermediary's reopening denial through the exercise of either general federal question jurisdiction under 28 U.S.C. 1331 or mandamus jurisdiction under 28 U.S.C. 1361. Pet. App. 30-32.

4. The court of appeals affirmed. Pet. App. 1-15. It concluded that the operative language in 42 U.S.C. 139500(a) triggering a provider's right of review before the Board—"a final determination \* \* \* of the intermediary \* \* \* as to the amount of total program reimbursement due the provider"—does not clearly encompass an intermediary's denial of a request to reopen a prior determination, and that the Secretary's reopening regulations and interpretative guidelines reasonably interpret the Medicare Act not to grant the PRRB jurisdiction over an intermediary's denial of a request to reopen. Pet. App. 4-7. The court found its conclusion "bolstered" by *Califano v. Sanders*, 430 U.S. 99, 108 (1977), in which this Court concluded that the Social Security Act, 42 U.S.C. 405(g), does not authorize federal courts to review a denial of reopening of a Social Security disability claim based on an alleged abuse of agency discretion. Pet. App. 7-8.

The court of appeals further concluded that 42 U.S.C. 405(h) precludes a district court from exercising its general federal question jurisdiction under 28 U.S.C. 1331 to review an intermediary's denial of a request to reopen, because petitioner's claims for additional reimbursement arise under the Medicare Act. Pet. App. 11-12. Finally, reasoning that a fiscal intermediary's "decision not to reopen [i]s discretionary," the court of appeals rejected petitioner's contention that the intermediary's denial of reopening is reviewable under the mandamus statute, 28 U.S.C. 1361. Pet. App. 14-15.

### SUMMARY OF ARGUMENT

I. The familiar two-step analysis of *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984), requires that, if Congress has not "directly spoken to the precise question at issue," a court must sustain an agency's interpretation of an Act of Congress so long as it is "based on a permissible construction of the statute." Moreover, where, as here, the Act confers legislative rule-making authority on the Secretary (see 42 U.S.C. 405(a) (as incorporated into the Medicare Act by 42 U.S.C. 1395(ii)), 1302(a), 1395x(v)(1)(A), 1395hh), the regulations "are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." See *Sullivan v. Zebley*, 493 U.S. 521, 528 (1990), quoting *Chevron*, 467 U.S. at 843-844. Here, the Secretary's reopening regulations are not "arbitrary, capricious, or manifestly contrary" to the Act.

A. The text of Section 139500(a) requires the PRRB to conduct an administrative hearing with respect to an intermediary's "final determination \* \* \* as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under [Medicare] for the period covered by [the provider's cost] report." That language refers to an intermediary's NPR, which constitutes the intermediary's final de-

termination of the total amount of annual reimbursement owed to the provider. The statutory phrase, however, does not clearly encompass an intermediary's refusal to revisit reimbursement determinations already made in a closed NPR. Neither the Act itself nor its history speaks to reopenings. The Secretary therefore permissibly exercised her broad rulemaking authority to allow a provider to seek reopening, but not to seek further review of a decision denying reopening. The Secretary's approach furthers Congress's intent to require providers to challenge substantive reimbursement determinations within the 180-day time period prescribed by 42 U.S.C. 139500(a)(3).

The Secretary's position also rests on a reasonable construction of her reopening regulations, which vest the "exclusive[]" "[j]urisdiction" for reopening with "that administrative body that rendered the last determination," 42 C.F.R. 405.1885(c), and provide for further review only "[w]here a revision is made \* \* \* after [a] determination \* \* \* has been reopened," 42 C.F.R. 405.1889. The plain text of those provisions fully supports the Secretary's conclusion that the Board lacks jurisdiction to review intermediary decisions denying reopening.

B. The Secretary's reopening regulations are reasonable and not arbitrary or capricious. The regulations are consistent with the Secretary's established treatment of reopening denials with respect to other payment determinations under the Medicare program. The regulations do not authorize intermediaries to deny reimbursement requests in an arbitrary fashion. Intermediaries frequently grant providers' requests to reopen, and intermediaries are subject to continuing oversight by the Secretary to ensure that reopening requests are considered in accordance with the Secretary's regulations and interpretive guidance. The regulations, moreover, rationally balance the Secretary's interest in administrative finality with the need to provide a limited

means for the correction of errors after the intermediary's determination in the NPR has become final.

II. Federal courts do not have subject matter jurisdiction under 28 U.S.C. 1331 to review intermediary decisions denying reopening. The third sentence of 42 U.S.C. 405(h), incorporated into the Medicare Act by 42 U.S.C. 1395ii, expressly bars federal question jurisdiction under 28 U.S.C. 1331 over actions "to recover on any claim" arising under the Medicare Act. Section 405(h) consequently precludes federal question jurisdiction over petitioner's claim to recover additional reimbursement for owners' compensation costs under the Secretary's reopening regulations. That result is entirely consistent with this Court's decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), which permitted a federal court under 28 U.S.C. 1331 to consider an attack on the validity of the Secretary's regulation under Part B of the program when such challenge otherwise would be altogether immune from judicial review. Petitioner's claims for additional reimbursement do not raise such a facial attack, and 42 U.S.C. 139500 provided petitioner with an adequate opportunity to challenge the intermediary's substantive reimbursement determination.

III. The federal mandamus statute, 28 U.S.C. 1361, is not a basis for reviewing reopening denials. Review by mandamus is barred by 42 U.S.C. 405(h). In any event, mandamus relief is not available unless the plaintiff has exhausted all other avenues of relief and the defendant owes the plaintiff a clear nondiscretionary duty. *Heckler v. Ringer*, 466 U.S. 602, 616 (1984). Those requirements are not met in this case, because an intermediary's decision to reopen is discretionary. Likewise, petitioner has not stated a claim for mandamus relief with respect to the underlying calculation of the amount of owners' compensation costs owed to petitioner. Petitioner did not exhaust that claim by appealing its NPR under 42 U.S.C. 139500, and the determination of petitioner's

reasonable owners' compensation costs under the Act and the Secretary's implementing regulations is discretionary.

IV. This Court held in *Califano v. Sanders*, 430 U.S. 99, 105-107 (1977), that the Administrative Procedure Act (APA), 5 U.S.C. 701-706, is not an independent basis of subject matter jurisdiction to review agency action. Petitioner offers no basis for reconsidering that decision, and *Califano v. Sanders* consequently forecloses jurisdiction under the APA to hear challenges to reopening denials by intermediaries.

### ARGUMENT

#### I. 42 U.S.C. 139500 DOES NOT PROVIDE A RIGHT OF REVIEW OF AN INTERMEDIARY'S DENIAL OF A REQUEST TO REOPEN A FINAL REIMBURSEMENT DETERMINATION

A provider of services under Part A of the Medicare program has a right to a hearing before the Provider Reimbursement Review Board (PRRB) with respect to a "cost report" filed by the provider if it is "dissatisfied with a final determination of [a fiscal intermediary] as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under [Medicare] for the period covered by [the provider's cost] report." 42 U.S.C. 139500(a). The provider then has a right to judicial review of the "final decision" of the Board following such a hearing. 42 U.S.C. 139500(f)(1). The principal issue in this case is whether Section 139500(a) confers on providers a right to administrative review by the Board of an intermediary's refusal to revisit prior reimbursement determinations. In the Secretary's view, the phrase "final determination \* \* \* as to the amount of total program reimbursement due the provider" refers to the notice of amount of program reimbursement (NPR), not to a refusal to reconsider the NPR. Petitioner, in contrast,

contends that the statutory language must be read to encompass an intermediary's decision denying a provider's request under the Secretary's regulations to reopen a specific finding in a prior NPR.

The starting point in any case of statutory construction is, of course, the language of the Act itself. If a court determines that an Act of Congress speaks clearly "to the precise question at issue," the court "must give effect to the unambiguously expressed intent of Congress." *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984). If "the statute is silent or ambiguous with respect to the specific issue," however, the court must sustain the agency's interpretation and implementing regulations if they are "based on a permissible construction of the statute." *Id.* at 843; see also *Regions Hosp. v. Shalala*, 118 S. Ct. 909, 915 (1998) ("[i]f the agency's reading fills a gap or defines a term in a reasonable way in light of the Legislature's design, we give that reading controlling weight"). In this case, moreover, Congress has conferred legislative rule-making authority on the Secretary in the implementation of the Medicare Act, including the authority to issue regulations that govern reimbursement determinations under the Act. See 42 U.S.C. 405(a) (as incorporated into the Medicare Act by 42 U.S.C. 1395ii), 1302(a), 1395x(v)(1)(A), 1395hh; *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 418-419 & n.13 (1993); *Sullivan v. Zebley*, 493 U.S. 521, 525 n.2, 528 (1990); *Heckler v. Campbell*, 461 U.S. 458, 466 (1983). In that situation, the regulations "are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Sullivan v. Zebley*, 493 U.S. at 528 (quoting *Chevron*, 467 U.S. at 843-844).<sup>5</sup> Here, far from being

<sup>5</sup> Petitioner's amici contend (Br. 25-26) that the Secretary's interpretation is not entitled to deference because the question in this case pertains not to "the complexities of the Medicare program," but a jurisdic-

arbitrary, capricious, or manifestly contrary to the Act, the Secretary's construction of Section 139500(a) is fully consistent with the Act and is plainly reasonable.

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tional question over which courts are more familiar. In *Commodity Futures Trading Commission v. Schor*, 478 U.S. 833, 845 (1986), however, this Court rejected the notion that a court has "superior expertise" with respect to an agency's adjudicatory jurisdiction and concluded that an agency's position is due "substantial deference" whenever "a dispute centers on whether a particular regulation is 'reasonably necessary to effectuate any of the provisions or to accomplish any of the purposes' of the Act the agency is charged with enforcing." The Court, on numerous occasions, has deferred to an agency's interpretation of its adjudicatory jurisdiction. See, e.g., *Reiter v. Cooper*, 507 U.S. 258, 269 (1993); *EEOC v. Commercial Office Prods. Co.*, 486 U.S. 107, 115 (1988); *NLRB v. United Food & Commercial Workers Union*, 484 U.S. 112, 123 (1987); see also *Mississippi Power & Light Co. v. Moore*, 487 U.S. 354, 380-382 (1988) (Scalia, J., concurring in the judgment) (collecting cases on question of deference to agency's interpretation of statute concerning its jurisdiction). Here, the Medicare Act confers broad authority on the Secretary to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs" under the Act. 42 U.S.C. 1395hh(a)(1); accord 42 U.S.C. 405(a), 1302(a), 1395x(v)(1)(A); see also 42 U.S.C. 139500(e) (authorizing PRRB to make rules "not inconsistent with the \* \* \* regulations of the Secretary" to carry out provisions of Section 139500). The Secretary's rulemaking authority therefore encompasses the ability to prescribe regulations defining the type of agency decision subject to administrative review. See *Weinberger v. Salfi*, 422 U.S. 749, 766 (1975) (noting Secretary's rulemaking authority to define agency's "final decision" triggering right of judicial review under 42 U.S.C. 405(g)). Moreover, the administrative process by which intermediaries make reimbursement determinations that are subject to review by the Board, and ultimately the Secretary, necessarily relates to the "complex and highly technical regulatory program" over which the Secretary has particular expertise. *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (quoting *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991)).

**A. The Text Of Section 139500(a) Supports The Secretary's Construction**

**1. Section 139500(a) Is Most Naturally Read To Confer A Right To Review Of A Notice Of Amount Of Program Reimbursement Issued By An Intermediary**

Section 139500(a) states that "[a]ny provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by [the] Provider Reimbursement Review Board" if each of three conditions is satisfied. The first condition is that "such provider \* \* \* is dissatisfied with a final determination of the \* \* \* intermediary \* \* \* as to the amount of total program reimbursement due the provider \* \* \* for the period covered by [the provider's cost] report." 42 U.S.C. 139500(a)(1)(A)(i). The remaining two conditions are that the amount in controversy is \$10,000 or more, and that the provider files a "request for a hearing" within 180 days after notice of the intermediary's final determination. 42 U.S.C. 139500(a)(2) and (3).

The language quoted above is most naturally read to confer a right to Board review of the intermediary's substantive reimbursement determination at the end of each cost year, but not of the intermediary's mere refusal to revisit that determination. That conclusion is especially evident from the fact that Section 139500(a) confers a right to a "hearing" by the Board, which includes the right to present evidence and cross-examine witnesses. See 42 U.S.C. 139500(c). Such a hearing is of course appropriate on review of the NPR, but even petitioner does not contend that it is entitled to the sort of evidentiary hearing specified by Section 139500(c) concerning an intermediary's denial of a motion to reopen a prior determination. Compare *Califano v. Sanders*, 430 U.S. 99, 108 (1977).

Moreover, to the extent the Act itself does not define the operative statutory terms, “[their] meaning is left to the Secretary to flesh out by regulation.” *Weinberger v. Salfi*, 422 U.S. 749, 766 (1975); see also n. 5, *supra*. The Secretary’s regulations make clear that providers have a right to obtain Board review of an intermediary’s annual determination as reflected in the NPR, but not its decision denying a request to reopen a prior NPR.

The Secretary has defined an intermediary’s “final determination” under Section 139500(a)(1)(A)(i) to mean a “determination of the amount of total reimbursement due the provider, pursuant to [42 C.F.R.] 405.1803 following the close of the provider’s cost reporting period.” 42 C.F.R. 405.1801(a)(1) and (3) (emphasis added). Section 405.1803 of the regulations, in turn, specifically requires the intermediary to issue a “notice of amount of program reimbursement”—the NPR—by “furnish[ing] the provider \* \* \* a written notice reflecting the intermediary’s determination of the total amount of reimbursement due the provider.” 42 C.F.R. 405.1803(a); see also *Regions Hosp. v. Shalala*, 118 S. Ct. at 913 (“[t]he [NPR] determines the total amount payable to the provider for Medicare services during the reporting period”); *HCA Health Servs., Inc. v. Shalala*, 27 F.3d 614, 617 (D.C. Cir. 1994) (“it is fairly straightforward to conclude that the NPR is the intermediary’s ‘final determination . . . as to the amount of total program reimbursement’”). The Secretary had promulgated similar regulations even before Congress created the PRRB. See 37 Fed. Reg. 10,722, 10,724 (May 27, 1972) (the NPR “shall \* \* \* explain the intermediary’s determination of total program reimbursement due the provider for the reporting period covered by the cost report”). The NPR also is a “final and binding” determination as to the total amount of reimbursement owed to a provider in a given cost year, unless the provider timely appeals the NPR within the 180-day

time period under Section 139500(a), or the intermediary in fact has revised its determination through a reopening. 42 C.F.R. 405.1807.

Accordingly, under the statutory and regulatory framework, the operative “final determination \* \* \* as to the total amount of program reimbursement” in this case is the intermediary’s issuance of four NPRs on March 29, 1991, J.A. 34-56, and not the intermediary’s denial, three years later, of petitioner’s request to reconsider petitioner’s allowable owners’ compensation costs, J.A. 28-29. Thus, petitioner was required under Section 139500(a) to seek administrative review before the PRRB within 180 days of its NPRs or not at all.<sup>6</sup>

**2. Section 139500(a) Does Not By Its Terms Confer A Right To Review Of An Intermediary’s Refusal To Revisit Its Final Determination**

a. Petitioner and its amici do not dispute that Section 139500(a) refers to an intermediary’s issuance of the NPR, or that providers must seek administrative review of that determination by the intermediary within 180 days after receiving notice of the determination. Rather, petitioner and

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<sup>6</sup> Amici are incorrect in asserting (Br. 7) that the Secretary’s interpretation is inconsistent with the Court’s decision in *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988). That case involved the interpretation of the word “dissatisfied” in Section 139500(a)(1)(A)(i) upon a provider’s direct appeal of an NPR. Amici similarly err in suggesting (Br. 14) that the Secretary’s interpretation conflicts with 42 U.S.C. 139500(d), which authorizes the Board to revise matters covered by a cost report “even though such matters were not considered by the intermediary in making [its] final determination.” This Court explained in *Bethesda Hospital Association*, 485 U.S. at 406, that Section 139500(d) applies “once [the Board] obtains jurisdiction pursuant to subsection (a).” Thus, whether the PRRB has jurisdiction to review a denial of a provider’s reopening request “ultimately must rest upon [Section] 139500(a).” *HCA Health Servs., Inc.*, 27 F.3d at 617.

its amici argue (Pet. Br. 6-12, 17-18; Amici Br. 6-7) that Section 1395oo(a) inevitably must also extend to any subsequent decision by the intermediary denying a provider's request to revisit a final NPR. See also *State of Oregon v. Bowen*, 854 F.2d 346, 349 (9th Cir. 1988) (concluding a reopening denial falls within Section 1395oo(a)(1)(A)(i) because it "directly implicate[s]" the total amount of Medicare reimbursement owed in a given cost year). That interpretation, however, is compelled by neither the text of Section 1395oo(a) nor its history.

As an initial matter, the Act makes no mention of reopenings; the intermediary's ability to reopen its previous final determination is purely a creature of the Secretary's regulations. The Secretary first promulgated reopening regulations shortly before Congress created the PRRB in Section 1395oo, 37 Fed. Reg. at 10,725, and did so under the Secretary's general rulemaking authority, *HCA Health Servs., Inc. v. Shalala*, 27 F.3d at 618-619. Nothing in the language of Section 1395oo compels an intermediary, much less the PRRB, to consider a provider's request for additional reimbursement if the provider fails to challenge the intermediary's NPR within 180 days of receiving notice of its issuance. See *Good Samaritan Hosp. Reg'l Med. Ctr. v. Shalala*, 85 F.3d 1057, 1062 (2d Cir. 1996) ("42 U.S.C. § 1395oo, read by itself, leaves us in a 'quandary' as to the availability of PRRB review over a reopening decision") (quoting *HCA Health Servs., Inc.*, 27 F.3d at 618-619). The Act's silence as to reopenings therefore confirms that the Secretary may permissibly construe Section 1395oo(a) to grant providers a right to administrative review of substantive reimbursement determinations by intermediaries,

but not of intermediaries' subsequent refusals to reopen and reconsider such determinations.<sup>7</sup>

The history of Section 1395oo(a) is fully consistent with the Secretary's interpretation. Before Congress created the PRRB in 1972, the Act did not provide for administrative or judicial review of Medicare reimbursement determinations, but simply directed the Secretary to "periodically determine the amount which should be paid \* \* \* to each provider of services with respect to the services furnished by it" and to pay "at such time or times as the Secretary believes appropriate (but not less often than monthly) \* \* \* the amounts so determined." Pub. L. No. 89-97, § 102(a), 79 Stat. 297 Social Security Act § 1815, 42 U.S.C. 1395g(a)). In response to provider complaints that there was "no specific

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<sup>7</sup> Amici contend (Br. 10) that the Secretary's interpretation is inconsistent with the Board's authority to review intermediary determinations other than the NPR. See, e.g., 42 C.F.R. 405.1889 (intermediary determinations revising an NPR upon a reopening); 42 C.F.R. 413.30(c) (denial of routine cost limit exception requests); 42 C.F.R. 413.40(e)(4) (denial of rate-of-increase ceiling adjustment requests); 42 C.F.R. 413.86(e)(1)(v) (cited in *Regions Hosp.*, 118 S. Ct. at 918) (per-resident amount determinations under 42 U.S.C. 1395ww(h)). Unlike a mere refusal to revisit a prior "final determination," however, the Secretary has recognized that the Board may review certain *new* substantive reimbursement determinations by an intermediary that affect an initial or revised NPR. See generally PRM § 2926, App. A. In any event, the Secretary has authority under the Act to interpret and amplify the Board's jurisdiction so long as her regulations are not otherwise precluded by statute. See n.5, *supra*. Amici similarly suggest (Br. 9 n.5) that the Act's express preclusion of PRRB review in 42 U.S.C. 1395oo(g) and 1395yy(e)(8) necessarily means that Congress intended to mandate a right to PRRB hearing with respect to any decision by an intermediary relating to a reimbursement determination. Sections 1395oo(g) and 1395yy(e)(8), however, relate to payment determinations specified *by statute*, and therefore do not reflect an intent by Congress to require review of an intermediary's decision denying a reopening request under a procedure bestowed solely by the Secretary's regulations.

provision for an appeal \* \* \* of a fiscal intermediary's final reasonable cost determination," H.R. Rep. No. 231, 92d Cong., 1st Sess. 108 (1971), Congress, in 1972, established the PRRB to afford a hearing with respect to such final determinations upon a provider's request for a hearing within 180 days after notice of the intermediary's final determination. Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1420; see also S. Rep. No. 1230, 92d Cong., 2d Sess. 248 (1972). Although Congress plainly intended Section 1395oo to authorize an administrative hearing on the intermediary's annual final determination as to the total amount of program reimbursement, nothing in the Act's history suggests that Congress intended to afford providers a right to a hearing by the PRRB whenever an intermediary denies a request to revisit that final determination.

b. Petitioner argues (Br. 11-14) that a right to review by the PRRB is mandated by 42 U.S.C. 1395x(v)(1)(A)(ii), which requires the Secretary to establish regulations to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." Petitioner contends that Section 1395x(v)(1)(A)(ii) requires the Secretary to provide for reopening of closed cost reports and that Section 1395x(v)(1)(A)(ii)'s "plain language" and purpose "to provide a fair method to make retroactive adjustments" conflict with the Secretary's position of "unreviewability." Br. 12-13 (quoting *State of Oregon*, 854 F.2d at 349-350); see also *Amici* Br. 9-10 n.6.

In *Good Samaritan Hospital v. Shalala*, 508 U.S. 402 (1993), however, this Court specifically rejected the contention that Section 1395x(v)(1)(A)(ii) requires the Secretary to alter retroactively her substantive determinations as to the amount of Medicare reimbursement due to providers. Rather, the Court held that the Secretary reasonably con-

strued Section 1395x(v)(1)(A)(ii) narrowly to refer only to the year-end book balancing of advance monthly estimated payments to providers (see 42 U.S.C. 1395g) with the final amounts determined by the intermediary in the NPR to be reimbursable under the Act and the Secretary's implementing regulations. *Good Samaritan Hosp.*, 508 U.S. at 414-420; see also p. 3, *supra*; J.A. 36, 40, 44, 48 (computing the "net amount due provider" by comparing difference between petitioner's "total Medicare reimbursable cost" and its "total interim payments"). The final year-end reconciliation in the NPR is entirely distinct from a later decision by the intermediary denying a provider's request to redetermine the NPR. Accordingly, Section 1395x(v)(1)(A)(ii) is wholly consistent with the Secretary's conclusion that Section 1395oo does not require the Board to review an intermediary's denial of a reopening request.<sup>8</sup>

c. The fact that reopening is not mandated by the Act is significant for another reason as well. The Secretary's regulations authorize reopening only "with respect to findings on matters at issue" in a prior determination by the intermediary. 42 C.F.R. 405.1885(a). The regulations therefore permit a provider, like petitioner, to request an intermediary to reconsider its previous final determination with respect to one or more particular cost items covered by the NPR. See J.A. 32 (petitioner's request for "re-opening of the 1989 cost report to recompute the allowable owners' compensation"). An intermediary's denial of a request to revisit one or more of those specific "findings," however, does not

<sup>8</sup> In light of *Good Samaritan Hospital*, the Ninth Circuit has acknowledged that its conclusion in *State of Oregon*, 854 F.2d at 349, that Section 1395x(v)(1)(A)(ii) is the source of statutory authority for a reopening procedure has been substantially "undercut." *French Hosp. Med. Ctr. v. Shalala*, 89 F.3d 1411, 1418 n.8 (9th Cir. 1996); accord *Mt. Diablo Hosp. v. Shalala*, 3 F.3d 1226, 1231 (9th Cir. 1993).

determine "the amount of total program reimbursement" within the meaning of Section 139500(a). As the court of appeals explained, "a decision not to reopen \* \* \* does not, in and of itself, establish an amount of total program reimbursement as required by the statute." Pet. App. 7 (quoting *Good Samaritan Hosp. Reg'l Med. Ctr.*, 85 F.3d at 1061). Accordingly, the Secretary has reasonably concluded that the denial of a request to reopen under her regulations merely constitutes the intermediary's decision not to alter its previous "final determination \* \* \* as to the amount of total program reimbursement." See *Good Samaritan Hosp. Reg'l Med. Ctr.*, 85 F.3d at 1061 ("a reopening denial is a refusal to revisit the final determination"). Such a decision is not the "final determination" itself, and therefore does not trigger a right to hearing before the Board.

**3. The Secretary's Interpretation Furthers Congress's Intent To Require Providers To Appeal Their NPRs Within 180 Days**

Under 42 U.S.C. 139500(a)(3), a provider must challenge an intermediary's NPR within 180 days of receiving notice of the final determination embodied in the NPR. That requirement supports the Secretary's conclusion that Section 139500(a) does not extend to reopening denials. It would largely defeat the congressional goal of finality reflected in Section 139500(a)(3) to construe the Act to require the Secretary to confer a right of review by the Board with respect to all refusals by intermediaries to reopen reimbursement determinations in final NPRs, each of which would, under petitioner's reading of the Act, constitute a new "final determination" subject to a mandatory Board hearing and subsequent judicial review. The Secretary's interpretation therefore "avoid[s] frustrating the congressional purpose to impose a 180-day limitation upon [PRRB] review of a fiscal

intermediary's final determination on an initial cost report." Pet. App. 8.

This Court in *Califano v. Sanders*, 430 U.S. 99 (1977), reached a similar conclusion in holding that 42 U.S.C. 405(g) does not authorize judicial review of the Secretary's refusal to reopen a decision on a claim for Social Security benefits. The Court observed at the outset that "the opportunity to reopen final decisions and any hearing convened to determine the propriety of such action are afforded by the Secretary's regulations and not by the Social Security Act." *Sanders*, 430 U.S. at 108. The Court further explained (*ibid.*) that 42 U.S.C. 405(g) provides for judicial review only with respect to a "final decision of the Secretary made after a hearing," and that "a petition to reopen a prior final decision may be denied without a hearing as provided in \* \* \* 42 U.S.C. § 405(b)."<sup>9</sup> The Court also reasoned that "an interpretation that would allow a claimant judicial review simply by filing—and being denied—a petition to reopen his claim would frustrate the congressional purpose, plainly evidenced in [42 U.S.C. 405(g)], to impose a 60-day limitation upon judicial review of the Secretary's final decision on the initial claim for benefits." *Ibid.*<sup>10</sup>

<sup>9</sup> Lower courts had concluded that 42 U.S.C. 405(b), which requires a hearing upon request with respect to "decisions as to the rights of any individual applying for a payment under this subchapter," did not apply to refusals to reopen such decisions pursuant to the Secretary's regulations. See, e.g., *Cappadora v. Celebrezze*, 356 F.2d 1, 4-5 (2d Cir. 1966) (Friendly, J.); *Filice v. Celebrezze*, 319 F.2d 443, 445-446 (9th Cir. 1963). The Secretary's interpretation of Section 139500(a) in this case is no different.

<sup>10</sup> Amici contend (Br. 12-13) that *Sanders* is distinguishable on the grounds that the Secretary's regulations in that case had no time limit; that the claimant filed a reopening request seven years after the original decision denying benefits; that the claimant did not proffer any new evidence; and that an ALJ reviewed the reopening denial. The regulations at issue in *Sanders*, however, "specified time limits after the date of initial determination" for seeking reopening unless certain conditions were satis-

That same analysis applies here. The Secretary's interpretation furthers "Congress' determination \* \* \* to limit judicial review to the original decision denying benefits" in order to "forestall repetitive or belated litigation of stale eligibility claims." *Sanders*, 430 U.S. at 108. By contrast, petitioner's construction of Section 139500(a) would nullify the 180-day time period prescribed by Section 139500(a)(3) and burden the Board and ultimately the courts with repetitive requests to reopen administratively settled matters.

**4. The Secretary's Reopening Regulations Confirm That There is No Right To Review By The Board**

The Secretary's regulations provide that "[j]urisdiction for reopening a determination or decision rests *exclusively* with that administrative body that rendered the last determination or decision." 42 C.F.R. 405.1885(c) (emphasis added). The Secretary has construed that provision to preclude further review of intermediary decisions denying reopening. The PRM, which provides interpretive guidance to providers and intermediaries, see *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995), states that "[a] refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 C.F.R. § 405.1885(c)." PRM § 2926, App. A, ¶ B.4; accord PRM § 2932.1 ("A provider has no right to a hearing on a finding by an intermediary \* \* \* that a reopening \* \* \* of a determination \* \* \* is not warranted.").

This Court has stated that it "must give substantial deference to an agency's interpretation of its own regulations." *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994). Thus, courts do not "decide which among several competing

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fied. 430 U.S. at 102. In any event, the Court did not rest its decision on the length of time that elapsed before the claimant requested reopening, or on the fact that an ALJ had reviewed the reopening request and denied it for lack of new evidence.

interpretations best serves the regulatory purpose. Rather, the agency's interpretation must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation." *Ibid.* (internal quotation marks omitted). Here, the Secretary reasonably has construed her reopening regulations not to provide for administrative review by the Board of reopening denials by intermediaries.

That interpretation is fully consistent with the text of 42 C.F.R. 405.1885(c), which vests "exclusive[]" "[j]urisdiction" over a reopening request with the "administrative body that rendered the last determination or decision." In this case, the intermediary—"that administrative body that rendered the last determination" with respect to petitioner's 1989 NPRs—had the "exclusive[]" "[j]urisdiction" to determine whether to reopen the NPRs on the owners' compensation issue. Petitioner argues (Br. 7-8) that Section 405.1885(c) simply confirms the intermediary's "discretion" to reopen and that the regulation "says nothing about reviewability" by the Board for alleged abuses of that discretion. The regulation prohibits such review, however, because it would divest the intermediary of its "exclusive[]" jurisdiction to reopen its own prior determination. At a minimum, that construction is not "plainly erroneous or inconsistent with the regulation." *Thomas Jefferson Univ.*, 512 U.S. at 512.

The Secretary's interpretation is further confirmed by the regulations' *express* authorization for administrative review when an intermediary affirmatively reopens and revises its prior determination. 42 C.F.R. 405.1889 (permitting Board review "[w]here a revision is made in a determination \* \* \* on the amount of program reimbursement after such determination \* \* \* has been reopened as provided in § 405.1885"). The regulations do not likewise grant providers a right to appeal when the intermediary declines to reconsider its prior determination. In light of the express provision for review of the revised NPR if the prior final

determination is reopened, "this omission provides persuasive evidence that [the Secretary] deliberately intended to foreclose further review of such claims." *United States v. Erika, Inc.*, 456 U.S. 201, 208 (1982). The regulations as a whole therefore support the Secretary's conclusion that the Board lacks jurisdiction to review reopening denials. See Pet. App. 5.

**B. The Secretary's Interpretation Of Section 139500(a) Is Reasonable**

**1. The Secretary's Interpretation Is Consistent With The Absence Of A Right To A Statutory Hearing And Judicial Review Of Other Reopening Denials Under the Medicare Program**

The Secretary's conclusion that providers do not have a right under Section 139500(a) to administrative review by the Board of reopening denials by intermediaries is fully consistent with her longstanding interpretation that reopening denials of other Part A and Part B benefit determinations are unreviewable. Just as Part A providers may seek to reopen NPRs under 42 C.F.R. 405.1885, the Secretary has promulgated similar regulations permitting individual beneficiaries under Part A, and physicians (and other suppliers of services) and individual beneficiaries under Part B, to request reopening of intermediary or carrier determinations denying claims for benefits. 42 C.F.R. 405.750(b), 405.841-405.842. Those regulations do not, however, permit administrative review of decisions denying requests to reopen. See Medicare Intermediary Manual § 3799.16; Medicare Carrier Manual § 12100.16. Moreover, because 42 U.S.C. 405(g) governs individual claims for benefits under Parts A and B (and physician claims under Part B), see 42 U.S.C. 1395ff and n.2, *supra*, this Court's decision in *Califano v. Sanders*, *supra*, forecloses any statutory right to a hearing concerning a reopening denial and precludes those

claimants from seeking judicial review of such denials. Thus, by construing Section 139500(a) not to confer a right to further review of reopening denials affecting providers under Part A, the Secretary rationally has determined that the Act should afford similar treatment with respect to all decisions denying reopening under the Medicare Act.

**2. The Reopening Regulations Do Not Permit Unchecked Or Arbitrary Action By Intermediaries**

Petitioner asserts (Br. 31-34, 36-38) that PRRB review is necessary to ensure that intermediary reopening decisions are not arbitrary or capricious. That contention is unwarranted. The Secretary has set forth detailed criteria to guide an intermediary's exercise of discretion in considering a reopening request. The Provider Reimbursement Manual states that "[w]hether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions" of the Secretary. PRM § 2931.2. HCFA also may instruct an intermediary to reopen a prior determination when HCFA concludes that the determination "is inconsistent with the applicable law, regulations, or general instructions issued by [HCFA]." 42 C.F.R. 405.1885(b). We have been informed by the Secretary that intermediaries frequently grant providers' reopening requests<sup>11</sup> and that HCFA regularly imparts guidance to intermediaries as needed to promote consistent application of, and adherence to, the reopening standards set forth in the Secretary's regulations and PRM.

<sup>11</sup> Although HCFA does not maintain nationwide statistics on reopening decisions, it estimates that intermediaries grant at least 30%-40% of providers' requests to reopen.

Petitioner's amici further contend (Br. 14-21) that the Secretary has conferred unlimited discretion on intermediaries that have an incentive to deny reopening requests in order to meet performance standards set by the Secretary. Amici also refer (Br. 17-18) to the Secretary's notice of proposed rulemaking to establish conflict-of-interest regulations with respect to Medicare Integrity Program contractors (42 U.S.C. 1395ddd (Supp. II 1996)), in which the Secretary recognized the "potential" for conflicts of interest "[w]hen a Medicare contractor owns a provider or supplier." 63 Fed. Reg. 13,590, 13,592 (Mar. 20, 1998). Those contentions, however, all ignore the salient fact that providers suspecting an intermediary of bias may challenge an intermediary's underlying substantive reimbursement determination by timely compliance with the review procedures set forth by Congress in Section 1395oo(a). Indeed, had petitioner pursued its statutory appeal rights with respect to its NPRs for 1989, petitioner would have been entitled to a full evidentiary hearing during which it could have raised any basis for contending that the intermediary's action was erroneous or arbitrary.

In any event, the Secretary has not delegated unbridled discretion to biased fiscal intermediaries. As an initial matter, petitioner offers no basis for inferring that intermediaries are predisposed against providers when considering requests to reopen. *Schweiker v. McClure*, 456 U.S. 188, 195 (1982) ("We must start \* \* \* from the presumption that the hearing officers [designated by private carriers] who decide Part B claims are unbiased."). Indeed, intermediaries are nominated by providers, 42 U.S.C. 1395h(a) and (d); 42 C.F.R. 421.104, and providers are free to request a change in their intermediary, 42 C.F.R. 421.106. The Secretary also has general oversight authority over intermediaries, 42 U.S.C. 1395h, and has established performance criteria to assure that intermediaries make "[c]orrect coverage and

payment determinations"; are "[r]esponsive[] to beneficiary concerns"; and "[p]roper[ly] manage[] \* \* \* administrative funds." 42 C.F.R. 421.120(a)(1)-(3); see also 42 C.F.R. 421.122. In the event of nonperformance or noncompliance with the Secretary's directives, the Secretary may take adverse action against an intermediary, including termination of its agreement. 42 U.S.C. 1395h; 42 C.F.R. 421.124, 421.126. Far from providing "strong incentives" to make decisions unfavorable to providers (Amici Br. 17), those regulations ensure that intermediaries properly perform their duty to make accurate determinations. Compare *Schweiker v. McClure*, 486 U.S. at 197.

Petitioner and its amici also argue (Pet. Br. 37; Amici Br. 13-14, 22) that the absence of review of reopening denials is inconsistent with this Court's decision in *Interstate Commerce Commission v. Brotherhood of Locomotive Engineers*, 482 U.S. 270, 279 (1987), which held that a denial by the Interstate Commerce Commission of a request to reopen a prior order was subject to judicial review under the Hobbs Administrative Orders Review Act (Hobbs Act), 28 U.S.C. 2344, to the extent that the reopening request was based on "new evidence" or "substantially changed circumstances." The Court found that reopening decisions based on alleged "material error" were committed to agency discretion and therefore unreviewable by virtue of 5 U.S.C. 701(a)(2) and that a contrary interpretation would be inconsistent with the Hobbs Act's 60-day limit upon judicial review. 482 U.S. at 277-284; see also *id.* at 280 ("If a judicial panel or an en banc court denies rehearing, no one supposes that that denial, as opposed to the panel opinion, is an appealable action."). The Court distinguished reopening requests based on "new evidence" or "changed circumstances," however, because otherwise the party seeking reopening "will have been deprived of all opportunity for judicial consideration—even on a 'clearest abuse of discretion' basis—of facts which,

through no fault of his own, the original proceeding did not contain." *Id.* at 279.

The Court's conclusion in *Brotherhood of Locomotive Engineers* that reopening requests based on new evidence or changed circumstance were subject to judicial review does not invalidate the Secretary's interpretation of the Medicare Act in this case. In *Brotherhood of Locomotive Engineers*, Congress expressly had authorized parties to petition the Commission to reopen its prior decisions based on "new evidence[] or \* \* \* substantially changed circumstances," 49 U.S.C. 10327(g)(1), and Congress further had authorized judicial review in the court of appeals over any "final order" of the Commission, 28 U.S.C. 2344. By contrast, the Medicare Act does not address reopening, and the issue in this case is whether there is a right to administrative review of an intermediary's denial of a request to reopen a "final determination \* \* \* as to the total amount of program reimbursement." 42 U.S.C. 1395oo(a). Moreover, this Court has concluded that courts lack subject matter jurisdiction to review reopening denials when that result is supported by the statutory scheme. See, e.g., *Sanders*, 430 U.S. at 102, 108 (no judicial review of reopening denials under 42 U.S.C. 405(g) even though reopening regulations permitted reopening upon discovery of new and material evidence); *SEC v. Louisiana Public Serv. Comm'n*, 353 U.S. 368, 371-372 (1957) (court of appeals lacked jurisdiction to review a Commission order denying a petition to reopen proceedings under 15 U.S.C. 79k(b), because that provision did "not include an order merely denying a petition to reopen").<sup>12</sup>

<sup>12</sup> Amici also err in relying (Br. 22) on the availability of judicial review of refusals to reopen deportation proceedings under the Immigration and Nationality Act. In *Giova v. Rosenberg*, 379 U.S. 18 (1964), this Court directed the court of appeals to review a denial of a motion to reopen a deportation proceeding. The government had conceded in that case, however, that a "final order[]" of deportation" under 8 U.S.C. 1105a(a) as it

Petitioner is in any event incorrect in contending (Br. 34-37) that its reopening request is necessary to present "new evidence" supporting its claims for additional reimbursement. Petitioner alleges that, after submitting its 1989 cost reports, it discovered that the intermediary had used an informal survey for the 1987 cost year to determine the allowable owners' compensation costs for some home health agency chains, but not for petitioner. J.A. 32, Pet. Br. 34-35. Petitioner was not prevented, however, from raising that contention before the Board and ultimately the courts. Petitioner was fully aware of its "protested" owners' compensation costs even before the intermediary issued the NPRs for the 1989 cost year, J.A. 50, and petitioner in fact sought a hearing before the PRRB with respect to the amount of its owners' compensation reimbursement for 1987 and the years subsequent to 1989. See Pet. 23. Moreover, had petitioner timely sought PRRB review of the 1989 NPRs, petitioner could have sought discovery of any salary surveys used by the intermediary to determine allowable owners' compensation costs for home health agency chains. 42 C.F.R. 405.1853(b); cf. 42 C.F.R. 405.1853(a) (requiring intermediary to present to the Board "all available documentary evidence in support of [the intermediary's] position," as well as "all relevant documents which formed the basis for its determination of the amount of program reimbursement").

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then existed should encompass an order denying reopening. The government argued that, although "[l]iterally" a reopening denial was not a "final order of deportation" under the Act, Congress nonetheless intended in that statute to "provide a single, unitary review procedure \* \* \* for every litigable issue that might arise in a deportation proceeding." No. 64-23 U.S. Br. at 15 (emphasis omitted); see also 8 U.S.C. 1105a(a)(6) (discussed in *Stone v. INS*, 514 U.S. 386 (1995)) and 8 U.S.C. 1252(b)(6) (Supp. II 1996) (recent authorization of judicial review of motions to reopen deportation proceedings under certain circumstances).

### 3. *The Reopening Regulations Reasonably Further The Goal Of Administrative Finality Under The Act*

The Secretary's interpretation of Section 139500(a) as not providing for PRRB review of intermediary reopening denials also reflects a reasonable balancing of the interests in preserving administrative finality with those of providing a limited procedure for correction of errors after the intermediary's determination in the NPR has become final. See PRM § 2930. By establishing in Section 139500(a)(3) a 180-day time period for providers to appeal the total amount of program reimbursement determined in the NPR, Congress afforded providers a limited period to challenge the lawfulness and accuracy of its program reimbursement. But "[i]f a provider permits that deadline to lapse, the Statute envisions no further appeal of the intermediary's decision." *HCA Health Servs., Inc.*, 27 F.3d at 620. At that point, the cost report is closed and final. 42 C.F.R. 405.1807(c); PRM § 2930.1A.

Balanced against the interests of finality is the Secretary's recognition of the appropriateness of making available a reopening procedure for the correction of errors in an otherwise final NPR if the provider requests or the intermediary initiates reopening within three years of the NPR and the criteria for reopening are satisfied. 42 C.F.R. 405.1885(a); PRM §§ 2930, 2931.A, 2931.2. The Secretary informs us that reopening often results in payment of additional program reimbursement to the provider. In the event the provider is dissatisfied with the result of a reopening, however, the regulations grant the provider 180 days to appeal the specific reimbursement matters that are actually reopened and addressed in a revised NPR. 42 C.F.R. 405.1889; *HCA Health Servs., Inc.*, 27 F.3d at 615; *French Hosp. Med. Ctr.*, 89 F.3d at 1422.

By contrast, since an intermediary's denial of a request to reopen does not alter the provider's total program reim-

bursement, the Secretary reasonably found no need to provide for PRRB review of an intermediary's decision denying reopening. As a result, the Secretary's interpretation rationally precludes the "belated litigation" of "stale" claims that could have been appealed within Section 139500(a)(3)'s 180-day period. *Califano*, 430 U.S. at 108.

Petitioner and its amici argue (Pet. Br. 14-17; Amici Br. 11-12; 19-21) that the Secretary's interpretation of the Act imposes an arbitrary double standard because the Secretary may require intermediaries to reopen a prior determination and, if necessary, to recoup reimbursement, if such determination is "inconsistent with the applicable law, regulations, or general instructions issued by [HCFA]." 42 C.F.R. 405.1885(b). They also refer to this Court's decision in *Regions Hospital*, 118 S. Ct. at 914, which upheld the Secretary's graduate medical education (GME) costs regulation that instructed intermediaries to apply a newly calculated "per-resident amount" in a base year to recoup overpayments made for GME costs in fiscal years still subject to reopening under 42 C.F.R. 405.1885. See 42 C.F.R. 413.86(e)(1)(iii). Petitioner and its amici accordingly contend that principles of administrative finality similarly must yield when providers seek to obtain additional reimbursement for cost reports still subject to reopening. That contention lacks merit.

In balancing the goal of administrative finality against the interest in affording a limited means to correct errors after finality has attached, the Secretary reasonably provided for reopenings at the direction of HCFA in order to protect the public fisc from unauthorized and wasteful expenditures. Each year, the Secretary makes total payments of approximately \$120 billion to approximately 38,000 providers participating in Part A of the Medicare program. See 1997 HCFA Statistics, HCFA Pub. No. 03403, at 27 (Table 30). Each of those providers submits an annual cost report

containing thousands of cost items for which reimbursement is sought. See *Athens Community Hosp., Inc. v. Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984) (The cost report is "a lengthy document consisting of numerous schedules, worksheets, and supplemental worksheets. \* \* \* [A] cost report, when completed, is approximately three-quarters of an inch thick."). It is neither administratively feasible nor efficient for the 37 intermediaries that currently service Part A providers to perform a detailed field audit of each item claimed on a cost report. Thus, the Secretary reasonably promulgated her reopening regulations in light of the practical need to reopen prior NPRs when there is reason to believe that intermediaries made payments that are not reimbursable under the Act. See *Regions Hosp.*, 118 S. Ct. at 917 (GME reaudit regulation reasonably permits Secretary "to carry out [her] official[] responsibility to reimburse only reasonable costs" and "prevent[s] payment of uncovered, improperly classified, or excessive costs"). Furthermore, if a prior determination is reopened, any new determination by the intermediary that requires the provider to repay sums it previously received is subject to administrative and judicial review. 42 U.S.C. 405.1889. That regulatory scheme fairly and sensibly permits the Secretary expeditiously to administer the program with a safety net that ensures that only reimbursable payments are made.

It is also rational for the Secretary to grant providers the right to request reopening but not the right to seek review of an intermediary's denial of a request to reopen. As sophisticated entities that "rely on Medicare as a major source of revenue to assure their financial survival" (Amici Br. 1), providers generally submit accurate cost reports each year. Cf. 42 U.S.C. 1395g(a) (prohibiting Medicare reimbursements unless provider submits adequate documentation); 42 C.F.R. 413.24(f)(2) (giving providers five months following close of fiscal year to submit cost report). Similarly, provid-

ers ordinarily scrutinize their annual NPRs and raise any challenges to them within the 180-day time period specified under 42 U.S.C. 1395oo(a)(3). The Secretary's reopening regulations recognize, however, that providers should be permitted "a reasonable period of time within which to seek or make corrections wherever an error has been discovered." PRM § 2930. Yet because of the enormous administrative costs to the program that would result from PRRB and judicial review of reopening denials by intermediaries with respect to any cost item reimbursed within the three years following an NPR, the Secretary has reasonably limited further administrative review of reopening decisions to only those instances when the intermediary has actually reopened and revised a prior determination.<sup>13</sup> Indeed, a contrary con-

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<sup>13</sup> Amici contend (Br. 19-21) that providers should be entitled to reap the benefit of any judicial decision that, if applied retroactively to NPRs issued within the preceding three years, would result in additional reimbursement. They therefore fault the Secretary's general policy to apply judicial decisions prospectively and to all pending administrative challenges, but not to settled cost reports. See, e.g., HCFA Ruling 97-2, Medicare and Medicaid Guide (CCH) ¶ 45,105 (1997) (Amici Br. a3-a4) (applying corrected adjustment methodology under "prospective payment system" to pending and future cases); see also 42 C.F.R. 405.850 (change in law does not warrant reopening under Part B). That criticism is unfounded. In cases in which the law has changed by a judicial ruling after the administrative decision becomes final and binding, the Secretary may decline to accord retroactive relief when the law applicable at the time of the intermediary's decision comported with the Secretary's construction of the Medicare Act, which the provider never challenged on direct appeal. Cf. *Bousley v. United States*, 118 S. Ct. 1604, 1609 (1998) (noting rule of *Teague v. Lane*, 489 U.S. 288, 310 (1989), that "new constitutional rules of criminal procedure will not be applicable to those cases which have become final before the new rules are announced"); *Reynoldsville Casket Co. v. Hyde*, 514 U.S. 749, 758 (1995) ("New legal principles, even when applied retroactively, do not apply to cases already closed."). The Secretary's decision to deny review of reopening denials based on subsequent judicial decisions therefore can hardly be declared arbitrary. See *Broth-*

clusion could dissuade agencies in a similar position from authorizing claimants to seek reopening in the first instance.<sup>14</sup>

## II. FEDERAL COURTS DO NOT HAVE JURISDICTION UNDER 28 U.S.C. 1331 TO REVIEW REOPENING DENIALS BY INTERMEDIARIES

### A. 42 U.S.C. 405(h) Prohibits Review Of Reopening Denials Under 28 U.S.C. 1331

Petitioner and its amici argue (Pet. Br. 18-23; Amici Br. 21-23) that, in the event the Court upholds the Secretary's interpretation of Section 1395oo(a), the Court should rely on a general presumption in favor of judicial review and hold that federal courts have federal question subject matter jurisdiction under 28 U.S.C. 1331 to review reopening

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*erhood of Locomotive Eng'rs*, 482 U.S. at 286 (petition for reconsideration that "merely urged the Commission to correct what [the moving party] thought to be a serious error of law \* \* \* should have been sought many months earlier, by an appeal from the original order"); *Federated Dep't Stores, Inc. v. Moitie*, 452 U.S. 394, 400 (1981) (rejecting "equitable doctrine" that "countenances an exception to the finality of a party's failure to appeal merely because his rights are 'closely interwoven' with those of another party" that chose to appeal).

<sup>14</sup> In light of the practical differences between the Secretary (who administers the Act with limited resources and without ready access to all the records of thousands of providers) and providers (which obtain reimbursement under the program based on evidence of their own operations to which they have full access), the Secretary could provide for different reopening rules with respect to each. Under her broad authority to issue regulations to establish procedures and methods of proof for determining reimbursable costs under the Act (42 U.S.C. 405(a) (as incorporated by 42 U.S.C. 1395ii), 1302(a), 1395x(v)(1)(A), 1395hh), the Secretary rationally could determine that the interests of finality and effective administration of the Medicare program support a regulatory scheme under which NPRs are subject to reopening only upon the Secretary's initiative. The Secretary permissibly could even conclude that those interests warrant complete elimination of reopening procedures.

denials by intermediaries. Such jurisdiction, however, is specifically precluded by the third sentence of 42 U.S.C. 405(h), incorporated into the Medicare Act by 42 U.S.C. 1395ii, which provides that "[n]o action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 \* \* \* of title 28 to recover on any claim arising under this subchapter."

This Court has made clear that the preclusive language of Section 405(h) is "sweeping and direct." *Salfi*, 422 U.S. at 757. In *Heckler v. Ringer*, 466 U.S. 602 (1984), this Court held that Section 405(h) bars federal courts from exercising federal question jurisdiction to hear "all 'claim[s] arising under' the Medicare Act." 466 U.S. at 615 (quoting 42 U.S.C. 405(h)); see also *Sanders*, 430 U.S. at 103 n.3, 109. The Court in *Ringer* further explained that Section 405(h) "broadly" extends to "any claims in which 'both the standing and substantive basis for the presentation' of the claims" is the Medicare Act. 466 U.S. at 615 (quoting *Salfi*, 422 U.S. at 760-761).<sup>15</sup>

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<sup>15</sup> Petitioner and its amici attempt to diminish the force of the Court's decisions in *Ringer* and *Salfi* by arguing (Pet. Br. 21-22; Amici Br. 22) that those decisions involved the exhaustion of administrative remedies, whereas providers here lack an administrative process to exhaust challenges to reopening denials. The availability of administrative review procedures, however, was irrelevant to the Court's conclusions in those decisions that Section 405(h) precludes federal question jurisdiction under 28 U.S.C. 1331 over claims under the relevant provisions of the Social Security Act, including its Medicare title. Rather, the question whether the claimants had exhausted their administrative remedies pertained solely to the availability of judicial review under other statutes. *Ringer*, 466 U.S. at 616-617 (28 U.S.C. 1361 and 42 U.S.C. 405(g)); *Salfi*, 422 U.S. at 763-766 (42 U.S.C. 405(g)); see also *Sanders*, 430 U.S. at 103 n.3 (Section 405(h) "has been held to require the exhaustion of available administrative procedures, to foreclose jurisdiction under the general grant of federal-question jurisdiction, \* \* \* and to route review through [42 U.S.C. 405(g)]") (emphasis added) (citing *Salfi*, 422 U.S. at 757, 761).

Those principles foreclose federal question jurisdiction over petitioner's claims. Petitioner seeks review of the intermediary's refusal to reopen the reimbursement determination for owners' compensation costs in petitioner's NPRs for 1989 or, alternatively, an increase in its reimbursement for owners' compensation costs. J.A. 61. The court of appeals properly found that "both the standing and substantive basis for the presentation of [those] claims comes from the plain language of the Medicare Act." Pet. App. 12. Accordingly, the third sentence of Section 405(h) bars a federal court from exercising jurisdiction under 28 U.S.C. 1331 to hear petitioner's claims for additional Medicare reimbursement.<sup>16</sup>

**B. Preclusion of Judicial Review Under 28 U.S.C. 1331 Is Consistent With *Bowen v. Michigan Academy of Family Physicians***

In *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), this Court concluded that a federal court had jurisdiction under 28 U.S.C. 1331 to review a challenge to the validity of a Medicare regulation governing payments to physicians under Part B of the Medicare program. At that time, 42 U.S.C. 1395ff provided for a hearing and judicial review of challenges to the amount of payments made under Part A but not Part B of the program. See 476 U.S. at 674 n.5 (quoting 42 U.S.C. 1395ff (1982)); *Erika, Inc.*, 456 U.S. at 207-208. Relying on the "strong presumption that

<sup>16</sup> Such review is also barred by the second sentence of Section 405(h), discussed at pp. 42-43, *infra*. Only one court has held that reopening denials are reviewable under Section 1331. *Memorial Hosp. v. Sullivan*, 779 F. Supp. 1410 (D.D.C. 1991). In that case, however, the district court did not mention Section 405(h) and found jurisdiction also present under 28 U.S.C. 1361, discussed *infra*, pp. 42-45. Moreover, "critical" to the court's decision was its finding that the Secretary specifically had directed the provider to seek reopening instead of directly appealing the NPR. 779 F. Supp. at 1412.

Congress intends judicial review of administrative action," the Court concluded that neither 42 U.S.C. 405(h) nor 42 U.S.C. 1395ff (as it then existed) precluded "challenges mounted against the *method* by which [the] amounts [of Part B benefits] are to be determined rather than [challenges to] the [amount] *determinations* themselves." 476 U.S. at 670, 675. Thus, the Court found that because the claimants had sought review not of an "'amount determination' which decides 'the amount of the Medicare payment to be made on a particular claim,'" but a facial attack on the validity of the Secretary's regulations, the district court had federal question jurisdiction to hear the claims. *Id.* at 676.

Petitioner argues (Br. 20) that *Michigan Academy* supports federal question jurisdiction in this case because petitioner contests the intermediary's application of 42 C.F.R. 413.102(b)(2)(i), which governs the reimbursement of owners' compensation costs. That claim, however, does not attack the underlying validity of a regulation; it simply avers that the intermediary misapplied a regulation when determining the amount of reimbursable owners' compensation costs owed to petitioner. Thus, petitioner's contentions do not resemble the sort of facial challenge that the Court in *Michigan Academy* found to be beyond the scope of Section 405(h)'s preclusive effect.<sup>17</sup>

Moreover, unlike the situation presented in *Michigan Academy* in which there was no other jurisdictional basis for obtaining judicial review of administrative action under Part

<sup>17</sup> Petitioner additionally argues (Br. 20) that its challenge to the validity of the Secretary's reopening regulations is the type of "collateral" methodology dispute that the Court in *Michigan Academy* found subject to review under 28 U.S.C. 1331. The parties concede, however, that the district court below had subject matter jurisdiction under Section 1395oo(f)(1) to review the final decision of the Board concluding that it lacks jurisdiction to review reopening denials. See Pet. Br. 20; Pet. App. 22; Gov't C.A. Br. 1.

B of the program as it then existed, see n.18, *infra*, Section 139500 explicitly affords Part A providers, such as petitioner, an avenue to challenge both the amount of Medicare payments and the methods by which those payments are calculated. When such review is available, the presumption of judicial review underlying the Court's decision in *Michigan Academy* is not "implicate[d]." *Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 207 n.8 (1994); see also *McNary v. Haitian Refugee Ctr., Inc.*, 498 U.S. 479, 498 (1991) ("Inherent in our analysis [in *Michigan Academy*] was the concern that absent such a construction of the \* \* \* statute, there would be 'no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program.'") (quoting *Michigan Academy*, 476 U.S. at 680). Thus, under Section 405(h) and this Court's decisions in *Ringer*, *Salfi*, and *Sanders*, Section 139500 is the sole means of obtaining judicial review of provider reimbursement claims arising under the Medicare Act. See, e.g., *St. Francis Med. Ctr. v. Shalala*, 32 F.3d 805, 812-813 (3d Cir. 1994), cert. denied, 514 U.S. 1016 (1995); *Westchester Mgmt. Corp. v. HHS*, 948 F.2d 279, 282 (6th Cir. 1991), cert. denied, 504 U.S. 909 (1992).<sup>18</sup>

<sup>18</sup> Subsequent legislative changes have eliminated the basis for continuing application of the holding in *Michigan Academy* even under Part B of the Medicare program. In 1986, Congress amended Section 1395ff to provide for administrative and judicial review of challenges to carrier determinations concerning the amount of payments made under Part B of the program. Pub. L. No. 99-509, § 9341(a)(1)(B), 100 Stat. 2037. In light of that amendment, lower courts have held that federal courts lack jurisdiction under 28 U.S.C. 1331 to review claims arising under Part B, including the type of "methodology" disputes at issue in *Michigan Academy*. See *American Academy of Dermatology v. HHS*, 118 F.3d 1495, 1500 (11th Cir. 1997) ("the amount/methodology distinction established in *Michigan Academy* is no longer viable"); *Martin v. Shalala*, 63 F.3d 497, 503 (7th Cir. 1995) ("the *Michigan Academy* distinctions drawn between 'amount of payment' and 'validity of the statute and regulations' chal-

The foregoing conclusion is not altered by the argument of petitioner and its amici (Pet. Br. 23; Amici Br. 21-23) that, if district courts lack jurisdiction under 42 U.S.C. 139500 to review intermediary decisions denying reopening, federal question jurisdiction under 28 U.S.C. 1331 is necessary to provide some route for judicial review of that type of agency action. Under that contention, any party could file multiple suits in federal courts under Section 1331 to challenge an agency's decision denying reopening notwithstanding the party's initial failure to seek review of the agency's underlying decision—and, here, notwithstanding the fact that Section 405(h) specifically channels all judicial review of agency action affecting provider claims under Part A of the Medicare program through the procedures set forth in 42 U.S.C. 139500. This Court should reject that contention. Petitioner is no different from the claimant in *Sanders*: petitioner had a right to administrative and judicial review of the intermediary's substantive determination of the amount it would be reimbursed, but petitioner failed to exercise that right. See also *Sanders*, 430 U.S. at 109 (recognizing that "federal question jurisdiction under 28 U.S.C. § 1331 is precluded by [Section 405(h)]"). In these circumstances, there is no basis for disregarding the express terms of Section 405(h) that bar federal question jurisdiction over "all 'claim[s] arising under'

lenges are no longer meaningful or necessary"); *Farkas v. Blue Cross & Blue Shield of Mich.*, 24 F.3d 853, 860 (6th Cir. 1994) (amount/methodology distinction is no longer "good law"); *Abbey v. Sullivan*, 978 F.2d 37, 42 (2d Cir. 1992) (*Michigan Academy*'s distinction "relegat[ed] to irrelevancy"); *National Kidney Patients Ass'n v. Sullivan*, 958 F.2d 1127, 1132 (D.C. Cir. 1992) ("the special treatment of part B [claims], based on the pre-October 1986 statutory differences, cannot survive the elimination of those differences"), cert. denied, 506 U.S. 1049 (1993); but see *Illinois Council on Long Term Care, Inc. v. Shalala*, 143 F.3d 1072, 1075 (7th Cir. 1998) (relying on *Michigan Academy* and concluding that Section 405(h) does not preclude "pre-enforcement review of a regulation's validity").

the Medicare Act." *Ringer*, 466 U.S. at 615 (quoting 42 U.S.C. 405(h)).

### III. THE MANDAMUS STATUTE, 28 U.S.C. 1361, DOES NOT FURNISH A BASIS FOR REVIEWING AN INTERMEDIARY'S DECISION DENYING REOPENING

Petitioner further argues (Br. 24-29) that federal courts may review an intermediary's denial of a provider's reopening request by the exercise of mandamus jurisdiction under 28 U.S.C. 1361. That argument, too, is foreclosed by 42 U.S.C. 405(h).

The second sentence of Section 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided"—i.e., except as provided in the Medicare Act itself. There can be no dispute that the decision of the intermediary denying petitioner's request to reopen is a "decision of the Secretary" for these purposes. See *Erika*, 456 U.S. at 206 n.4. Thus, that decision cannot be reviewed by any "tribunal," including a federal district court, except as provided in the Medicare Act itself. See *Sanders*, 430 U.S. at 110-111 (Stewart, J., concurring in the judgment). As we have explained, however, 42 U.S.C. 1395oo(f) provides no right of review here.<sup>19</sup>

<sup>19</sup> The third sentence of Section 205(h) of the Social Security Act (42 U.S.C. 405(h)), as originally enacted in 1939, provided that no action to recover on any claim arising under Title II of the Social Security Act could be brought "under section 24 of the Judicial Code" (53 Stat. 1371), which at that time contained all of the general grants of jurisdiction to the district courts. See 28 U.S.C. 41 (Supp. V 1934); *Salvi*, 422 U.S. at 756 n.3. When the mandamus statute was enacted in 1962, Congress placed it in Chapter 85 of Title 28 (see Act of Oct. 5, 1962, Pub. L. No. 87-748, 76 Stat. 744), which likewise contains all of the general grants of jurisdiction to the district courts and therefore is the successor to the prior 28 U.S.C. 41.

In any event, the Court made clear in *Ringer* that mandamus relief is an appropriate remedy "only if [the plaintiff] has exhausted all other avenues of relief and only if the defendant owes him a clear nondiscretionary duty." 466 U.S. at 616. Those requirements are not met in this case.

As explained above (see p. 18, *supra*), an intermediary's authority to reopen its prior final determination derives exclusively from the Secretary's reopening regulations. Those regulations provide that the decision whether to grant a provider's request to reopen is discretionary with the intermediary. Thus, the regulations provide that "[a] determination of an intermediary \* \* \* may be reopened \* \* \* by such intermediary \* \* \* on motion of the provider affected by such determination." 42 C.F.R. 405.1885(a) (emphasis added). Moreover, as petitioner and its amici concede (Pet. Br. 8; Amici Br. 24), the regulations elsewhere recognize the discretionary nature of the reopening decision by

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The 1962 amendment thereby placed the mandamus statute within the scope of the jurisdictional bar in the third sentence of 42 U.S.C. 405(h).

In the 1976 version of the United States Code, the codifiers revised the third sentence of 42 U.S.C. 405(h) to refer to "sections 1331 or 1346 of title 28," instead of "section 24 of the Judicial Code." That change was intended to reflect the 1948 revision of Title 28 (see 42 U.S.C. 405 note, at 518 (1976)) and, because it was not enacted by Congress, it had no legal effect. *North Dakota v. United States*, 460 U.S. 300, 311 n.13 (1983). In *Ringer*, which was decided in May 1984, the Court reserved the question whether the third sentence of 405(h), as then in effect, foreclosed mandamus jurisdiction. See 466 U.S. at 616.

Later in 1984, in Section 2663(a)(4)(D) of the Deficit Reduction Act of 1984 (Pub. L. No. 98-369, 98 Stat. 1162), Congress amended Section 205(h) of the Social Security Act to refer to "section 1331 or 1346 of title 28," instead of "section 24 of the Judicial Code." That amendment was one of a number of "technical corrections" that did not "chang[e] or affect[] any right, liability, status, or interpretation which existed (under the provisions of law involved) before that date." 98 Stat. 1160, 1171-1172; see also H.R. Conf. Rep. No. 861, 98th Cong., 2d Sess. 1413-1415 (1984).

providing that the "[j]urisdiction for reopening a determination \* \* \* rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R. 405.1885(c). Thus, because the Secretary does not have a "clear nondiscretionary duty" (*Ringer*, 466 U.S. at 616) to reopen petitioner's NPRs for 1989, petitioner has failed to satisfy the requirements for mandamus relief.

Petitioner nonetheless argues for the first time in its merits brief in this Court (Br. 25-27) that the Secretary owed petitioner a nondiscretionary "procedural" duty to pay it reasonable costs in accordance with 42 U.S.C. 1395x(v)(1)(A) and to follow her regulations governing owners' compensation costs, which provide that "[r]easonableness requires that the compensation allowance \* \* \* [b]e such an amount as would ordinarily be paid for comparable services by comparable institutions." 42 C.F.R. 413.102(b)(2)(i). That claim, however, fails both requirements for mandamus relief. First, petitioner failed to appeal its NPRs for 1989 under 42 U.S.C. 1395oo. Pet. 23; Pet. App. 3. Thus, petitioner did not "exhaust[] all other avenues" (*Ringer*, 466 U.S. at 616) to remedy the alleged error by the intermediary in determining the amount of petitioner's reimbursement for owners' compensation in 1989. See *id.* at 617 (mandamus relief not available when claimants "have an adequate remedy \* \* \* for challenging all aspects of the Secretary's denial of their claims for payment"); Pet. App. 13 (petitioner's "failure to appeal the initial determination would preclude mandamus review of that determination"). Mandamus review in that situation would flout "the purpose of the exhaustion requirement \* \* \* to prevent 'premature interference with agency processes' and to give the agency a chance 'to compile a record which is adequate for judicial review.'" *Ringer*, 466 U.S. at 619 n.12 (quoting *Salfi*, 422 U.S. at 765).

Second, the Secretary does not owe a clear nondiscretionary duty to pay petitioner a specific amount of owners' com-

pensation determined to be "reasonable" and "comparable" to other like institutions. Pet. Br. 26. By their nature, determinations of reasonableness and comparability necessarily require the discretionary exercise of the Secretary's expertise under the Act. See *Ringer*, 466 U.S. at 617 ("The Secretary's decision as to whether a particular medical service is 'reasonable and necessary' and the means by which she implements her decision \* \* \* are clearly discretionary decisions."); *Anderson v. Bowen*, 881 F.2d 1, 5 (2d Cir. 1989) (noting "considerable HCFA and carrier discretion in determining whether a charge is 'inherently reasonable'"). For those reasons, petitioner has failed to state a claim for mandamus relief under 28 U.S.C. 1361.

#### IV. THE APA DOES NOT PROVIDE A BASIS FOR SUBJECT MATTER JURISDICTION TO REVIEW AGENCY ACTION

Petitioner and its amici finally assert (Pet. Br. 29-38, 40; Amici Br. 24) that the Administrative Procedure Act (APA), 5 U.S.C. 706(2)(A), provides federal courts with subject matter jurisdiction to review an intermediary's decision denying reopening. This Court in *Sanders*, however, specifically held that Section 10 of the APA, 5 U.S.C. 701-706, does not vest federal courts with subject-matter jurisdiction to review agency action, including decisions denying reopening requests. 430 U.S. at 105-107. The Court explained that "the actual text of [Section] 10 \* \* \* nowhere contains an explicit grant of jurisdiction to challenge agency action in the federal courts," *id.* at 105-106, and that reading Section 10 as an implied grant of subject matter jurisdiction with respect to matters under the Social Security Act would be inconsistent with Congress's decision to retain Section 405(h) when it eliminated the amount-in-controversy requirement under 28 U.S.C. 1331(a) for suits against federal agencies and their officers and employees, 430 U.S. at 106-107.

"Considerations of *stare decisis* have special force in the area of statutory interpretation, for \* \* \* Congress remains free to alter what [the Court] ha[s] done." *Patterson v. McClean Credit Union*, 491 U.S. 164, 172-173 (1989). This Court therefore will not overrule precedent construing a federal statute unless intervening law has undercut the "conceptual underpinnings" of the decision; "later law has rendered the decision irreconcilable with competing legal doctrines or policies"; or there is "compelling evidence bearing on Congress' original intent." *Neal v. United States*, 516 U.S. 284, 295 (1996). None of those conditions is satisfied here. Indeed, petitioner does not even cite *Sanders*, much less contend that it is in error. Thus, under *Sanders*, the APA does not provide a jurisdictional basis for judicial review of reopening denials.

## CONCLUSION

The judgment of the court of appeals should be affirmed.  
Respectfully submitted.

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SEPTEMBER 1998

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Supreme Court, U. S.

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No. 97-1489

In The  
**Supreme Court of the United States**  
October Term, 1998

YOUR HOME VISITING NURSE SERVICES, INC.,  
*Petitioner,*

v.

SECRETARY OF HHS,  
*Respondent.*

On Writ Of Certiorari  
To The United States Court Of Appeals  
For The Sixth Circuit

PETITIONER'S REPLY BRIEF

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**PETITIONER'S REPLY TO RESPONDENT'S  
BRIEF ON THE MERITS**

This brief is submitted in accordance with United States Supreme Court Rule 24.4 which allows petitioner to reply and does not require a summary of the argument if the brief is appropriately divided by topical headings.

**I. Defining the phrase "final determination" in 42 U.S.C. § 1395oo.**

The respondent asserts that § 1395oo(a) is most naturally read to confer a right to review of a Notice of Amount of Program Reimbursement (NPR) but not an intermediary's "mere" refusal to revisit that determination, and seeks support for this conclusion in § 1395oo(a) which confers a right to a "hearing" by the Board, including the right to present evidence and cross-examine witnesses. Resp't Br. 15. Petitioner disagrees with this reading since it limits the plain language of the statute. See Pet'r Br. 7-10. The language simply refers to a final determination, not to the Notice of Amount of Program Reimbursement as the final determination. In *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) the Court refused to accept the Secretary's "strained interpretation" of the word "dissatisfied" as it appears in § 1395oo(a). *Id.* at 404. Similarly, the Court should refuse to accept the Secretary's restrictive reading of the phrase "final determination" and instead accept the plain meaning of the statute on this matter which would encompass the NPR as well as a final determination not to reopen a Medicare cost report as the decision which activates the right to review contemplated by § 1395oo(a). Petitioner qualified for a hearing under the statute:

- a. The amount in controversy is greater than \$10,000;
- b. The petitioner filed its request for a hearing within 180 days of the intermediary's refusal to reopen;

- c. The petitioner is dissatisfied with a final determination of the intermediary as to the amount of total reimbursement due the provider.

Here petitioner sought relief by resort to the administrative appeal process contemplated by Congress when it enacted § 1395oo(a). Social Security Amendments of 1972, H.R. Rep. No. 92-231 (1972), *reprinted in* 1972 U.S.C.C.A.N. 4989,5094. The Court in *Bethesda Hospital Association* recognized that petitioners who resort to the statutorily prescribed appeal procedure "stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement." *Id.* at 404-405. Petitioner respects the process outlined in the statute and seeks review within that system.

Section 1395oo is a broad jurisdictional statute. Respondent acknowledges that pursuant to the statute, it may "amplify" the Board's jurisdiction (Resp. Br. at 19 n.7). However, it lacks the authority to narrow the statutorily mandated jurisdiction of the Board to preclude it from reviewing a decision that meets the enumerated criteria under § 1395oo(a). The final determination is reviewable under the statute and therefore within Board jurisdiction for review. It is disingenuous for respondent to argue that, on the one hand, a denial of a request for reopening is not a "final determination . . . as to the amount of total reimbursement due the provider", while on the other hand, acknowledging that "reopening often results in additional program reimbursement to the provider." (Resp. Br. at 32) Petitioner maintains either action is a determination as to the amount of *total* program reimbursement due the provider. As such, the administrative review process is applicable.

Respondent characterizes a refusal to reopen as a decision not to alter the provider's total program reimbursement which the Secretary reasonably determined did not need to be reviewed.

Resp't Br. 32. The statute does not require an alteration in reimbursement as the mechanism which sets the

review process in motion. It simply states that a provider dissatisfied with a final determination as to the amount of total reimbursement due the provider for the period covered by such report may obtain a hearing. 42 U.S.C. § 1395oo(a). Petitioner met the statutory requirement.

The review process is crucial to providers who seek additional reimbursement. The intermediary's refusal to reopen a cost report cannot be dismissed as a "mere" refusal to revisit the previous determination. Indeed, the Secretary's contention that reopening regulations were promulgated to meet her "practical need to reopen . . . when there is reason to believe that intermediaries made payments that are not reimbursable under the Act," not only evidences her one-sided view of the reopening process, but is an acknowledgement that intermediaries do make mistakes. (Resp. Br. at 34). *See also Oregon v. Bowen*, 854 F.2d 346, 350 (9th Cir. 1988). With only 37 intermediaries to review the cost reports of 38,000 providers, it is conceivable, if not probable, that an intermediary may err in denying reopening to a provider that presents new and material evidence or finds a clear and obvious error. PRM § 2931.2. Without a review process, there is no remedy for the wrong.

## II. Refusal to Reopen is not always a refusal to revisit a previous determination.

Petitioner also notes that characterizing the refusal to reopen a cost report as a refusal to revisit the previous determination does not properly describe circumstances where new and material evidence is the basis for the request. If new and material evidence is at issue, then the intermediary would be reviewing it for the *first* time – a circumstance that cannot be considered a refusal to revisit a previous determination.

Respondent asserts petitioner did not claim entitlement to the sort of evidentiary hearing specified by

§ 1395oo(c). Resp't Br. 15. In fact, petitioner would certainly need an evidentiary hearing of that nature to present facts concerning the refusal to reopen in order to demonstrate an abuse of discretion. The Provider Reimbursement Review Board (PRRB) offers this type of hearing under § 1395oo(c) for providers located in the Ninth Circuit and has often found abuse of discretion in denials of reopening requests. See Pet'r Br. 31. Indeed, this Court envisioned some type of judicial review process available to determine whether such refusal was arbitrary, capricious, or an abuse of discretion. *Interstate Commerce Comm'n v. Brotherhood of Locomotive Eng'rs*, 482 U.S. 270, 271 (1987). Without the benefit of a hearing outlined by § 1395oo(c), a petitioner might have difficulty establishing its case of abuse of discretion. The only evidence in this case concerning the refusal to reopen is a two-page letter which offers conclusions rather than explanations. See J.A. 28-29. Petitioner again asserts that when an action is taken by the Secretary, that action must be taken in such a manner as to enable a reviewing court to determine whether or not the Secretary's discretion was exercised properly. *Dunlop v. Bachowski*, 421 U.S. 560, 573 (quoting *DeVito v. Shultz*, 300 F. Supp. 381, 383 (D.D.C. 1969)). Without the evidentiary hearing specified in § 1395oo(c), the reviewing court or the Board would have little evidence available for a decision. Since the review system for Medicare reimbursement issues contains an administrative process whereby a record will be developed which can later be judicially reviewed, it makes sense for a case involving a refusal to reopen to proceed through the PRRB process before judicial review, including the evidentiary hearing noted at § 1395oo(c).

### III. The reopening process is not purely a creature of the Secretary's regulations.

Petitioner continues to rely upon the reasoning of the Ninth Circuit in the *Oregon v. Bowen* case which preserves the presumption of judicial review and which found

support for Board jurisdiction in the plain meaning of § 1395oo, the congressional intent and in § 1395x(v)(1)(A)(ii), the statutory provision which requires retroactive corrective adjustments to assure that reimbursement is neither inadequate nor excessive. Later decisions in the Ninth Circuit have questioned reliance upon § 1395x(v)(1)(A)(ii) as statutory authority for the reopening process due to the Court's ruling in *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402 (1993). Resp. Br. 21, footnote 8. Petitioner believes the Ninth Circuit's concern in this regard is unfounded. The question presented in *Good Samaritan* was whether the Secretary must afford the six petitioning hospitals an opportunity to establish that they are entitled to reimbursement for costs in *excess of such limits*. The Court held that clause (ii) did not require such an opportunity. Petitioner agrees with that assessment but does not believe it stands for the proposition that § 1395x(v)(1)(A)(ii) cannot be considered the statutory basis for the reopening process. The Court's conclusion was based upon its refusal to accept the assertion that "reasonable" cost could be defined outside of the Medicare statute, which would allow for *more* Medicare reimbursement than the *methods* employed by the Secretary to define reasonable reimbursement. Petitioners in *Good Samaritan* were asking that *all* their costs be considered reasonable, even those which exceeded the cost limit established by the Secretary.

The Secretary's "book-balancing" argument was plausible in the circumstances of *Good Samaritan* where the competing interpretations were driven by the question of whether or not retroactive adjustment would be made to give providers *all* of their costs, even if their costs *exceeded* the limits. A different circumstance is presented in this case where the petitioner asserts that clause (ii) is statutory authority for the reopening process where retroactive corrective adjustment must be made to properly pay allowable reasonable costs *within* the applicable cost limits.

**(a) The statute requires the reopening process.**

Petitioner previously stated its position that the mandatory language noted in § 1395x(v)(1)(A)(ii) requires retroactive corrective adjustments to assure that reasonable costs for Medicare services are paid. Pet'r Br. 13-14. This position is supported by the discussion on pages 413-414 of the *Good Samaritan* decision where the Court notes the agency viewed clause (ii) as a directive for retroactive adjustment of payments for allowable costs, as determined by the established methods. See *Good Samaritan*, 508 U.S. at 413-414. After the 1972 cost limit amendments were added "the agency appears to have ascribed the same role to clause (ii), namely, to retroactively correct the differences between interim payments and *reasonable* costs - only as a result of the amendments the adjustments would now be based on the *new* definition of reasonable costs which includes the cost limits." *Good Samaritan*, 508 U.S. at 416. Since petitioner sought only to obtain its reasonable costs under the definitions developed by the Secretary, the Court's holding in *Good Samaritan* supports reliance upon clause (ii) as the statutory mandate for the reopening regulation. Clause (ii) requires the Secretary to promulgate regulations which allow a provider to request reopening for corrections to reasonable reimbursement which are authorized by the Secretary's own regulations concerning that reimbursement.

While Petitioner accepts the majority decision of *Good Samaritan*, the dissenting opinion also addressees points about the statute which should be considered in the present case. The dissenting opinion recognized the *mandatory* nature of the fourth sentence of § 1395x(v)(1)(A) and stated that clause (ii) requires the regulations to provide for suitable corrective adjustments where the method of determining costs produces a reimbursement that "proves to be either inadequate or excessive." *Good Samaritan*, 508 U.S. at 426.

Although petitioner agrees with the dissenting opinion where it finds that the Secretary is required to promulgate such regulations, it respectfully submits that the majority opinion of the Court was correct in not allowing payment in excess of the methods the Secretary established. Nevertheless, petitioner believes the dissenting opinion correctly recognized that clause (ii) should be considered statutory authority which *unambiguously* requires the promulgation of regulations allowing providers (and the Secretary) to seek adjustments if reasonable costs were not paid, or if excessive costs were paid. Indeed, this is the essence of petitioner's reliance upon clause (ii) as the statutory basis of the right to seek retroactive corrective adjustments through the reopening process when the Secretary failed to pay reasonable cost of owners compensation as defined by the Secretary's own regulations for owners compensation. See Pet'r Br. 13-15.

In further support for petitioners position that § 1395x(v)(1)(A)(ii) is statutory authority for the reopening regulations is the citation to that statutory section as the source of authority for the regulations contained at Subpart R - Provider Reimbursement Determinations and Appeals. (42 C.F.R. § 405.1801 et seq. citing Soc. Sec. Act §§ 205, 1102, 1814(b), 1815(a), 1833, 1861(v) (*which is 42 U.S.C. § 1395x(v)*), and 1871, 1872, 1878 and 1886.) The only regulations which concern retroactive corrective audit adjustments (the subject matter of clause (ii)) are the regulations which require reopening. Since the Secretary actually cited the statutory authority for her reopening regulation, it cannot be said that the reopening process is purely a creature of regulation. It is required by the Act itself and cannot be ignored.

The emphasis on statutory authority is being made to answer one of the questions at hand. Petitioner asserts that the *statute requires* the retroactive adjustments it sought. A review process is necessary to prevent the intermediary from ignoring the requirement. When there

is no review process, the Secretary is free to disregard the law without consequence.

**(b) Book balancing beyond year end.**

The respondent asserts that clause (ii) is statutory authority only for year end book-balancing, i.e., reconciliation of the actual "reasonable" costs under the regulations with the interim payments. The evidence in this case and many others demonstrates that the Secretary herself treats the reopening process as part of the book-balancing required by the statute. In *Good Samaritan* the Secretary asserts that the interim payments are based on the methods chosen by the Secretary to determine reasonable costs, but they are only anticipatory estimates . . . made before all relevant data are available. *Good Samaritan*, 508 U.S. at 411 (emphasis added). Respondent concedes that when data becomes available which indicates that a provider was *overpaid*, the intermediary reopens the cost report to recover the excess amount of reimbursement. This happened to this petitioner for the same cost report at issue herein. The 1989 Sneedville cost report was reopened because petitioner discovered and reported to the intermediary that a nurse employee did not have a valid license. See Pet'r Br. 14. The Secretary reopened the cost report to recover the money paid to the nurse because Medicare requires that nurses have valid licenses as a condition of payment. Nevertheless, when data became available to petitioner which showed its owners had been underpaid, the intermediary refused to reopen the same cost report. Petitioner asserts these two events are both properly characterized as book-balancing to reconcile actual costs to allowable costs.

The limited definition of the book-balancing as a year end function only for comparing the interim payments to the final amount allowable on the NPR at year end does not address circumstances in which new data about reasonable costs becomes available after the NPR is issued. Petitioner urges the Court to adopt its view of clause (ii)

as statutory authority which requires the Secretary to promulgate regulations to address retroactive corrective adjustments at year end or later. This approach would retain the book-balancing concept of clause (ii) without limiting its application to a year end timetable. In *Good Samaritan* neither the Court nor the agency limited the correction to a specific time frame whereas the Respondent now asserts that clause (ii) was construed by this Court to narrowly refer only to year end book-balancing of monthly estimated payments as compared to the final amounts determined by the intermediary in the NPR. Resp't Br. 20-21. The statutory language does not support this very narrow interpretation nor did the Court endorse that precise definition of book-balancing. Petitioner reads clause (ii) as statutory authority for the reopening process which should occur when retroactive corrective adjustments are needed. These adjustments might be apparent at year end, but events might also occur at a later date, after year end NPR's are issued, which would also call for the retroactive adjustment to cost. Defining the time frame for the book-balancing as being cut off at the year end (NPR stage) for the Secretary (as well as the provider) would severely restrict the intermediary's ability to make corrective adjustment when mistakes are discovered after the NPR is issued. As it stands now, only the provider is restricted to the year end timetable since the Secretary can and will reopen beyond year end to recover reimbursement. Instead of accepting this inequity, petitioner asks this Court to rule that the three year time period within which cost report requests for reopening must be made, should be read in tandem with the time period for book-balancing under clause (ii). This would allow the intermediary three years to correct errors and to make retroactive corrective adjustments. This is the more plausible reading of the statute.

Additional support for the three year period being the appropriate time frame within which to make book-balancing corrective retroactive adjustments can be found in the brief submitted by the Secretary of Health and

Human Services in *Regions Hosp. v. Shalala*, 118 S.Ct. 909 (1998), where she argued that the reaudit rule for GME was appropriate because it does not permit the Secretary to reopen administratively settled cost reports to recoup overpayment to providers during those "closed periods." Brief for the Respondent at \*15, *St. Paul-Ramsey Medical Center, Inc. v. Shalala*, 1997 WL 567286 (No. 96-1375) (reported as *Regions Hosp. v. Shalala*, 118 S.Ct. 909 (1998)); (See *id.* at 12-13, n.5 where the Secretary describes the time frame for reopening for purposes of altering the total amount of reimbursement as expired as of three years and one day after the initial NPR, in essence defining a closed period as one which is beyond the three year period). The brief went on to state that although the 1984 cost report had paid excessive reimbursement for GME costs, no recoupment action was taken against it because the "cost report had been finally determined." *Id.* at 13. This brief demonstrates that in *Regions Hosp.*, the Secretary placed emphasis upon the three year time period for reopening. The cost report is described as closed, "finally" determined and no longer subject to administrative review or reopening if the three-year time period had elapsed.

Now the Secretary wants to limit the time period for change to 180 days, where she previously argued the three-year time frame as the applicable statute of limitations for change. The Secretary should not have the advantage in both circumstances. The Secretary would limit the provider to the 180-day statute of limitations for requesting changes by way of appeal of the NPR and yet allow herself three years to go back to the providers and recover funds.

Respondent defends this approach (Br. 33) by citing the Secretary's responsibility to the public fisc, and yet Congress saw fit to place the providers and the Secretary on an even playing field when it drafted the language of clause (ii) which states that the Secretary *shall* promulgate regulations which provide for the making of suitable retroactive corrective adjustments where the aggregate

reimbursement produced by the methods of determining costs proves to be *either* inadequate or excessive. The statute contains a mandate for the Secretary to promulgate regulations for this process. Therefore, the Secretary is incorrect in her assertion that she may choose to eliminate the reopening process altogether. Resp't Br. 36, n.14.

#### IV. The Interest in Finality

Respondent argues that it would be inconsistent with concepts of administrative finality to require the Secretary to confer a right of review by the Board with respect to all refusals by intermediaries to reopen reimbursement determinations. Petitioner asserts that it is the Secretary's position which defeats the goal of finality. If the Court adopts the Secretary's position as correct, the logical response from providers would be to file more PRRB appeals in order to preserve their right to retroactive corrective adjustments in the event of discovery of new and material evidence or a clear and obvious error after the 180th day. In other words, the 180 days for appeal to the Board would be the only guarantee of an appellate process available for providers under the Secretary's reading of the Act. Any wrongful conduct discovered on the 181st day could be insulated from judicial review. In this sense, the Secretary's interpretation of the Act would actually defeat finality because it would encourage providers to file more PRRB appeals within this limited 180 day period as a precautionary measure. This interpretation of the Act creates the potential of the Board appeal, filed within 180 days of the NPR, being the providers' one and only chance for obtaining corrective retroactive adjustments. As the Secretary's own Ruling No. 97-2 reveals, she will not reopen settled cost reports to make corrections if providers do not have pending appeals, even when courts have determined her regulations for payment unlawful. See Amici Br. App. 1-3. This approach leaves the provider that did not file an appeal underpaid even if the cost report is still subject to reopening within

the three-year period if there is a refusal to reopen the cost report.

Under petitioner's view, it would be more appropriate to allow providers a meaningful right to request reopening within the three-year time period if the appropriate circumstances justify such a request. Petitioner's view of the statute, which allows review of the refusal of the request, would not impair finality since the requests for reopening would occur only when the providers discovered new and material evidence or a clear and obvious error and would remain limited within the three year time period for revision. Contrast the Secretary's system which would actually encourage increased litigation through numerous appeals. This would leave fewer cost reports finalized. The Secretary's approach defeats the congressional goal of finality. This Court stated that "only when a petition to reopen and reconsider an agency order alleges new evidence or changed circumstances is the agency's refusal to reopen subject to judicial review, and then, only as to whether such refusal was arbitrary, capricious or an abuse of discretion." *Interstate Commerce Comm'n*, 482 U.S. at 271. Often facts and circumstances which warrant review come to light after the initial 180 day period for appeal of an NPR expires. A review of the reopening process will assure that providers receive proper consideration when these situations occur.

#### **V. The reopening regulations do permit unchecked and arbitrary action by intermediaries**

The respondent asserts that the Secretary has set forth detailed criteria to guide an intermediary's exercise of discretion in considering a reopening request. Based upon the existence of this criteria, the respondent believes the reopening regulations do not permit unchecked or arbitrary action. Resp't Br. 27. The fact that criteria are set forth does not guarantee that the intermediaries will abide by it. In this case, no government official has reviewed the intermediary decision to assure

it is consistent with the criteria noted by respondent. There is no evidence in the record that anyone, other than the individual who signed the letter denying the request for reopening, ever considered petitioner's grounds for making the request. There was no substantive explanation concerning the refusal to reopen. There was no description of the process which was used to make the decision to deny the request. As Amici pointed out, the individual employee of the insurance company (intermediary) could have flipped a coin to make the decision.

There is in fact, evidence in this case that the intermediary knew the determination was incorrect but still refused to reopen and make the appropriate adjustments. Petitioner met the criteria for a reopening when it submitted new and material evidence concerning the discovery of the intermediary's failure to use the salary survey (developed by the previous intermediary) to determine the petitioner's owners compensation. It demonstrated a clear and obvious error had been made when petitioner's owners were paid less than their peers. Payment was therefore not in accordance with the law. The record shows the intermediary steadfastly refused to settle the issue in the one and only cost reporting period (1989) which was not pending on appeal to the Board. The respondent tells this Court there are mechanisms to protect the provider from an abuse of discretion and yet in this very case we have documents which demonstrate the refusal to reopen cost reports for 1989 to correct the same error which was corrected in six other cost reporting periods. (The 1988 cost reports had no adjustments to owners' compensation, nor did the later closed reports for 1995 and 1996).

Petitioner invites this Court's attention to evidence of an abuse of discretion in the form of the administrative resolution (settlement) of all petitioner's pending PRRB cases on the subject of owners' compensation. On April 3, 1997, petitioner filed a Motion to Request Addition of Documents as an Exhibit in the case. The Sixth Circuit referenced this material in the footnote 1, page 4 of its

decision where the court described the document as two letters purporting to resolve the outstanding cases between the intermediary and petitioner through an administrative resolution. *See* Pet. App. The Sixth Circuit refused to address the documents because they were not considered by the District Court. Petitioner could not have offered the documents for consideration at the District Court because the administrative resolution did not occur until October 4, 1996, almost seven months after the District Court ruling on March 22, 1996. The Sixth Circuit said consideration of the documents would not have altered their ruling and the court would not accept the documents noting that they did not address the 1989 year. (The 1989 year was not addressed because the intermediary settled every year *except* 1989.)

This evidence was offered to demonstrate abuse of discretion when the intermediary refused to reopen the 1989 cost report. Petitioner references this evidence as rebuttal to respondent's assertion that the reopening process does not permit unchecked or arbitrary action by intermediaries. The respondent tells this Court that HCFA regularly imparts guidance to intermediary's as needed to promote consistent application of and adherence to the reopening standards set forth in the Secretary's regulations and PRM. Resp't Br. 27. Apparently, the consistent application of the reopening standard does not equate to consistent application of the owners compensation guidelines which were applied to settle six PRRB cases for this petitioner.

Respondent adds a footnote to say that HCFA does not maintain statistics but estimates that 30%-40% of providers' requests to reopen are granted. Resp't Br. 27. Petitioner does not believe the estimate is even remotely accurate, but even if it were, that still means 60%-70% of providers' requests to reopen are denied and unreviewable according to the Secretary. There is absolutely no factual basis offered for the self-serving claim that 30%-40% of providers' requests are granted. Whereas the facts of this case offer an actual example of a refusal to

reopen in the face of clear and convincing evidence that the reopening should have been granted. Simple math with inflation factors could have been used to calculate the appropriate amount of owners compensation for 1989, the one and only year the intermediary refused to correct. And yet, the intermediary continued to refuse to reopen the cost report to make the corrective retroactive adjustment, all of which demonstrates the respondent is wrong when it asserts the reopening regulations do not permit unchecked or arbitrary action by the intermediary. This is one of many cases which demonstrates arbitrary and capricious action on the part of the intermediary.

#### VI. Federal Court jurisdiction under 28 U.S.C. § 1331.

Petitioner maintains that federal question jurisdiction is available for cases which do not seek to shortcut the administrative review process, but simply fall outside of the administrative review process. In support of this position petitioner continues to rely upon the Court's ruling in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), where the Court focused upon the importance of judicial review of the regulation in question. Petitioner believes 42 U.S.C. § 1395oo(a) does allow a review process, but in the event the Court accepts the Secretary's view on this issue, petitioner again would assert reliance upon federal question jurisdiction to resolve this matter. Respondent's discussion of the changes in jurisdiction which occurred when the amount in controversy was extinguished for federal question jurisdiction do not address the fact that Congress made the change in order to open the door to litigation in federal court that might otherwise be denied.

"An anomaly in Federal jurisdiction prevents an otherwise competent United States district court from hearing certain cases seeking 'non-statutory' review of Federal administrative action, absent the jurisdictional amount in controversy required by 28 U.S.C. section 1331, the general

'Federal question' provision. These cases 'arise under' the Federal Constitution or Federal statutes, and the committee believes they are appropriate matters for the exercise of Federal judicial power regardless of the monetary amount involved." *Califano v. Sanders*, 430 U.S. 99, at 99, footnote 7(1967), quoting the Senate Judicial Committee S. Rep. No. 94-996, p. 12 (1976) (emphasis supplied); see H.R. Rep. No. 94-1656, p. 13 (1976).

Although the petitioner is aware of the preclusionary language retained in 405(h) which respondent would apply to defeat federal question jurisdiction in this case, it is unreasonable to apply both the preclusionary language in conjunction with the concepts of exhaustion to prohibit all judicial review to situations where new and material evidence or a clear and obvious error arise after the 180 day period for the appeal from the initial Notice of Program Reimbursement. If the Secretary's reading of the Act requires elimination of judicial review through the prescribed administrative route, then it is reasonable for providers to resort to the judiciary via the federal question statute for jurisdiction to resolve this matter. Petitioner maintains the Court's ruling in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986) is applicable to this controversy if an appeal is not allowed under 42 U.S.C. § 1395oo. The petitioner presented two collateral challenges in this matter: the validity of the Secretary's reopening regulation 42 C.F.R. § 405.1885(c) and the intermediary's failure to abide by 42 C.F.R. § 413.102(b)(2)(i) which requires that owners compensation be such an amount as would ordinarily be paid by comparable institutions. Refusal to reopen the cost report to correct the error could also be defined or characterized as an abuse of discretion which is collateral to the underlying claim for additional owner's compensation. The failure to abide by the regulations governing owners compensation is also collateral to the underlying claim for owners compensation. When claims involve matters

outside the articulated statutory review process, jurisdiction should be available under § 1331. The presumption of judicial review in every possible context cannot be dissolved by the Secretary's interpretation of the Act alone.

#### VII. Federal Court jurisdiction under 28 U.S.C. § 1361

Respondent asserts that petitioner raises "for the first time" the Secretary's nondiscretionary duty to pay reasonable costs. Resp't Br. 44. This is not true. Petitioner directs respondent's attention to the Complaint filed in District Court and to petitioner's Reply Brief to the Petition for Writ. See J.A. 58, ¶4; 60 ¶14; Pet'r Reply Br. 1-2. Petitioner continues to rely upon its arguments as previously submitted on this issue. The Secretary owes a clear non-discretionary duty to pay in accordance with the criteria established by regulation 42 C.F.R. 413.102(b)(2)(i) to determine the amount of owners compensation.

#### VIII. Federal Court Jurisdiction under the Administrative Procedure Act

Respondent contends that this Court held in *Califano v. Sanders*, 430 U.S. 99 (1977), that Section 10 of the APA, does not vest federal courts with subject matter jurisdiction to review agency action, including decisions denying reopening requests. Resp't Br. 45. The question of the application of the APA to this controversy is being submitted with that decision in mind. However, the APA was addressed in *Good Samaritan* where the Court concluded the petitioner's challenge was in effect, in all but name, a challenge to the validity of methods and to their adequacy as gauges of reasonable cost and went on to recognize that "The Secretary has construed the statute to allow such attacks, not via clause (ii), but rather . . . by way of the arbitrary and capricious provision of the Administrative Procedure Act, 5 U.S.C. 706." *Good Samaritan*, 508 U.S. at 420. The Court noted that petitioners had invoked to APA at the Court of Appeals, where their

claim was rejected, but did not renew the APA claims in this Court. *Id.* at n. 16. This brings us to the question at hand where petitioner seeks a corrective retroactive adjustment because it was not paid in accordance with the Secretary's regulations and further alleges the refusal to reopen to make the corrective retroactive adjustment was an abuse of discretion, arbitrary and capricious. Petitioner herein did renew its claims under the APA as an alternative basis for jurisdiction and would urge this Court to reconsider its position in this regard as stated in *Califano v. Sanders*, 430 U.S. 99 (1977).

Petitioner's case is also distinguishable from *Sanders* because that case involved a previously adjudicated claim which had already been reviewed through the administrative process. In *Sanders*, the claimant received the benefit of the administrative review as the claim passed through several steps of the appeal process. As a result, an Administrative Law Judge found the claimant ineligible for benefits and the Appeals Council sustained that decision. *Sanders* p.102. Not until seven years later did the respondent file a second claim, which was treated as a request for reopening because no new evidence or changed circumstances were alleged. *Id.* at 103. In the present case, the petitioner did not receive the benefit of any review process even though new and material evidence was offered to support the request to reopen its cost reports. Here we have the complete lack of any type of review process for the refusal to reopen the cost report even though new and material evidence discovered after the 180 day period for requesting administrative review in the first instance had elapsed.

Another distinguishing fact is the subject matter of the issue itself. *Sanders* concerned disability eligibility, a decision which is based upon an individual's medical condition. This is different from the calculation and recalculation which often occurs with Medicare reimbursement. The portions of the Medicare statute which must be construed in this case concern the right to retroactive corrective adjustments of Medicare reimbursement after

the 180-day period for appeal has elapsed. In *Sanders*, there was no retroactive corrective adjustment provision of law at issue.

Respondent asserts that this Court will not overrule precedent construing a federal statute unless intervening law has undercut the "conceptual underpinnings" of the decision. Resp't Br. 46. Although *Sanders* spoke to judicial review of a refusal to reopen, the conceptual underpinnings were developed in the context of a disability claimant's case, not the Medicare provider's cost reporting process. This Court has not yet been presented with the question of a Medicare provider's right to review when an intermediary refuses to reopen a cost report. *Stare decisis* is the policy of courts to stand by precedent and not to disturb a settled point. Petitioner asserts this is a case of first impression for the Court and while *Sanders* may provide guidance on the matter, its holding does not settle the precise issue at hand.

Whether the APA can be used as an independent grant of jurisdiction in this circumstance must be examined in light of the Court's holding in *Sanders*, as well as the Court's later decisions regarding judicial review of administrative action. In *Sanders* the Court concluded the APA did not afford an implied grant of subject matter jurisdiction permitting judicial review of agency action. The conclusion was based in part upon the 1976 Congressional action in re-defining § 1331 by deleting the monetary amount requirement. As mentioned earlier in this brief, the legislative history shows that Congress deleted the jurisdictional amount in order to open the door for cases seeking review of federal administrative action. (*Sanders* at 107 footnote 7) Since it is clear that Congress sought to fill a gap by eliminating the jurisdictional amount requirement in § 1331, it does not follow that the APA should remain unavailable if § 1331 does not fill the gap. The legislative action reveals congressional concern for judicial review. Petitioner seeks judicial review, first and foremost by resorting to the administrative appeal

process set out in 42 U.S.C. § 1395oo. But in the alternative, federal question jurisdiction should be available and if it is not, then the APA should be considered as a grant of subject matter jurisdiction for the review of the final administrative action which petitioner believes is an abuse of discretion.

In *Sanders*, this Court respectfully acquiesced to the Congressional policy choice, which the Court read as designed to forestall repetitive or belated litigation of stale eligibility claims. *Sanders* at 108. The Medicare Act shows Congress policy choice of correcting mistakes by requiring retroactive corrective adjustments. 42 U.S.C. 1395x(v)(1)(A)(ii). While petitioner believes Congress also envisioned an appeal process via § 1395oo(a), if this Court disagrees, then petitioner would request reconsideration of the APA as an independent jurisdictional grant to allow Medicare providers access to federal court for the review of violations of federal law which would otherwise remain completely insulated from judicial review.

### CONCLUSION

Petitioner urges the Court to adopt the position stated by the Ninth Circuit in *Oregon v. Bowen*, and to reject the Secretary's interpretation of § 1395oo as inconsistent with the plain meaning of the statute, congressional intent, and the presumption of judicial review. In the alternative, the Court should find jurisdiction in federal district court to review a denial of the request for reopening under federal question jurisdiction, the Court's mandamus powers, or the Administrative Procedure Act.

Respectfully submitted,

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**IN THE  
Supreme Court of the United States**

—  
October Term, 1998  
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**YOUR HOME VISITING NURSE SERVICES, INC.,**  
*Petitioner,*

v.

**DONNA E. SHALALA,**  
Secretary of Health and Human Services,  
*Respondent.*

—  
**BRIEF OF *AMICI CURIAE***  
**Oklahoma Hospital Association**  
**Oregon Association of Hospitals & Health Services**  
**Louisiana Hospital Association**  
**Washington State Hospital Association**  
**THA – An Association of Hospitals and Health Services**  
**Texas Association of Hospitals & Healthcare Organizations**  
**Certus Corporation**

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## QUESTION PRESENTED

Whether specific consequences of insulating the reopening process from review should be considered in determining if there is jurisdiction for review by administrative or judicial bodies of fiscal intermediaries' refusals to reopen Medicare providers' cost reports?

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## MOTION FOR PERMISSION TO FILE *AMICUS* *CURIAE* BRIEF

Because factual circumstances, with a significant bearing on the issues pending before the Court in this case, have developed since the filing of petitioner's opening brief, *amici curiae* request leave of the Court to file this *amicus* brief in support of petitioner, Your Home Visiting Nurse Services, Inc., concurrent with petitioner's reply brief.<sup>1</sup> These facts, which relate to the respondent's non-compliance with a federal court order in Medicare reimbursement litigation in Oklahoma, are fully detailed below. Although not parties, *amici* ask that the Court accept this submission on grounds similar to those set forth under Rule 25.5 of the Supreme Court Rules, which allows parties to file supplemental briefs based on new material not available in time to be included in any earlier brief.

*Amici* have obtained the written consent of petitioner to the submission of this brief. See Appendix A, at App. 1. Respondent Donna E. Shalala, Secretary of Health and Human Services ("the Secretary") has declined to so consent,

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<sup>1</sup> Counsel for *amici curiae* listed on the cover authored this brief in whole. No party, other than *amici curiae*, its members or counsel has made a monetary contribution to the preparation or submission of this brief.

despite the fact that the factual circumstances giving substance to this brief arose *after* the date for filing of petitioner's opening brief.<sup>2</sup>

Further, in withholding consent, respondent has asserted that since the Oklahoma litigation concerned a Medicare regulation not at issue in this case, filing of this *amicus* brief is not warranted. Respondent has misunderstood the purpose of this brief.

Of greatest significance to this case is not the fact that the Oklahoma federal district court invalidated the Secretary's regulation. Rather, it is the Secretary's position, as taken in briefing and oral argument which occurred in September 1998, after opening briefs were filed herein, that she can refuse to advise fiscal intermediaries that her regulation had been declared void *ab initio*, i.e., that it had never been a valid interpretation of the law. She bases such refusal on the grounds that giving notice of such invalidation would be tantamount to ordering reopenings of those cost

<sup>2</sup> *Amici* recognize that if the Court accepts this brief, the Secretary may not have the opportunity to file a written reply. However, *amici* do not believe that the Secretary will be prejudiced in that *amici* simply seek to inform the Court of a recently developed factual situation illustrating a result of the Secretary's position that refusals to reopen costs reports are unreviewable. The Secretary cannot claim surprise or unfamiliarity with the facts. *Amici* urge the Court to consider this brief for the light it sheds on the real-world effect of the Secretary's legal position.

report determinations based on the invalidated regulation. She asserts that since the reopening process is solely within *her* purview, the court cannot force her and, by extension, her intermediaries, to take any such action. *Amici* here do not seek to re-litigate the substance of the Oklahoma case. They seek to advise this Court of this factual situation, which illustrates the significant consequences of denying administrative and/or judicial review of a decision not to reopen a cost report. For such reason, *amici* respectfully request that this brief be accepted.

#### IDENTIFICATION AND INTERESTS OF

##### *AMICI CURIAE*

*Amici curiae* are six state associations of health care providers and Certus Corporation. The state associations, which include the Oklahoma Hospital Association, Oregon Association of Hospitals and Health Systems, Louisiana Hospital Association, Washington State Hospital Association, THA – An Association of Hospitals and Health Systems (Tennessee), and The Association of Texas Hospitals and Healthcare Organizations, provide leadership and assistance to member hospitals and health systems on financial issues, including Medicare reimbursement issues. Most of the associations' members are providers of health care services under the Medicare program established

pursuant to 42 U.S.C. § 1395 *et seq.*, and rely on Medicare payments as a major source of revenue. The Court's decision in this case as to whether there is administrative and/or judicial review of refusals to reopen a cost report to correct erroneous Medicare reimbursement determinations will have significant financial consequences for these health care providers.

Certus Corporation is a newly formed provider of financial, reimbursement, and regulatory compliance advisory services for hospitals and health systems. Its founders are Medical Reimbursement Advisors, Inc., Certus Enterprises, LLC, Carlson Price Fass & Company, Inc., ELACOR Resources Group, Inc., and Healthcare Financial Advisors, Inc., all nationally known entities that consult with hospitals and health systems on Medicare reimbursement issues.

As is the case with the American Hospital Association and the Federation of American Health Systems, which have also submitted an *amicus* brief in support of petitioner ("AHA brief"), the hospitals and health systems represented by *amici* have the same general interests in the integrity of the Medicare payment process as described in the AHA brief, p. 2. Moreover, these hospitals and health systems have very specific interests arising in response to the

Secretary's longstanding unwillingness, contrary to congressional intent, to adequately reimburse health care providers that treat a disproportionate share of low-income patients. As further explained below, federal district and circuit courts in the jurisdictions where *amici* are located have invalidated a regulation promulgated by the Secretary that illegally limited Medicare disproportionate share reimbursements to such providers. The Secretary has refused to rescind the offending regulation; instead, she has specifically directed her fiscal intermediaries to refuse to reopen cost reports to correct erroneous disproportionate share reimbursement determinations.

Very recently, in an apparent direct contravention of a federal district court order, the Secretary refused to inform her fiscal intermediaries of the federal court decision invalidating the disproportionate share regulation. She has continued to maintain that she has absolute and unreviewable discretion to direct that cost report determinations not be reopened, despite the reliance of those determinations on the invalid regulation. If this Court issues a blanket ruling that there is no avenue of appeal from a refusal to reopen cost report determinations, even in the face of federal court decisions invalidating the regulation invoked to limit disproportionate share reimbursements, then respondent will

have the power to ignore the law unfettered by any check to her arbitrary exercise of authority. If this Court rules in accordance with the Secretary's position, then certain providers such as those represented by *amici* will have no ability to secure the additional reimbursement for treatment of low income patients that Congress intended them to have.

### SUMMARY OF ARGUMENT

*Amici curiae* concur in the arguments set forth in the briefs of petitioner and AHA and do not here restate them. Rather, *amici* seek to bring to the Court's attention recent actions of the Secretary in a case in the United States District Court for the Western District of Oklahoma, *Anadarko Municipal Hospital v. Shalala*, No. CIV-97-0288-A ("*Anadarko*"). In *Anadarko*, the court invalidated, as void *ab initio*, the Secretary's Medicare disproportionate share ("DSH") regulation<sup>3</sup> because it contradicted the clear and manifestly obvious meaning of the congressionally enacted formula for calculating compensation adjustments to providers furnishing care to low-income patients.<sup>4</sup>

<sup>3</sup> 42 C.F.R. § 412.106(b)(4).

<sup>4</sup> Also currently pending before the same district court is *Anadarko Municipal Hospital, et al. v. Shalala*, No. 98-564-A ("*Anadarko II*"). This action, filed after the *Anadarko* decision, involves essentially the same issues and essentially the same plaintiffs, but covers different cost-reporting years. In her answer to the *Anadarko II* complaint, the Secretary avers that she will recalculate the hospitals' DSH adjustments

After the date for filing opening briefs in this case, the Secretary advised the court and parties in *Anadarko* that, in spite of the court's declaration that the regulation was void *ab initio*, she was not required to notify her fiscal intermediaries of its invalidity or of the fact that any determination made by fiscal intermediaries pursuant to the invalidated DSH regulation was inconsistent with applicable law. Absent such notice, the Secretary insists, her fiscal intermediaries are not required to reopen providers' cost reports to correct the consequences of the invalidated regulation. Especially when considered in conjunction with a prior ruling issued by the Secretary in 1997 in which she specifically instructed intermediaries *not* to reopen settled cost reports to correct reimbursements based on the invalid DSH regulation, the Secretary's recent actions have disturbing implications for our legal system. Indeed, the Secretary's actions in the *Anadarko* case provide an actual illustration of the kind of abuses which will arise out of insulating reopening determinations from review by any administrative or judicial body. The Court should take into account the recent events in *Anadarko* when considering whether some type of review should be available to ensure

in accordance with HCFA Ruling 97-2 (the Ruling that limits reopenings to cost reports not yet finalized as of Feb. 27, 1997).

that a refusal to reopen a provider's cost report is not arbitrary and capricious or an abuse of discretion.

### ARGUMENT

#### **I. By Seeking To Insulate Her Reopening Decisions From Judicial Scrutiny In *Anadarko*, The Secretary Seeks To Preserve Her Longstanding Hostility To The Congressional Mandate To Adjust Compensation For Providers That Treat A Disproportionate Share Of Low-Income Patients.**

In order for the Court to appreciate the significance of the Secretary's actions in *Anadarko*, it is important to understand how the Secretary's DSH regulation failed to reflect the congressional mandate to provide additional reimbursement to health care providers serving the poor and how the Secretary, through her current no-reopening policy, is still seeking to avoid that congressional mandate.

In 1983, Congress enacted a statute, 42 U.S.C. § 1395ww(d)(5)(C)(i) ("Medicare statute"), which directed the Secretary to adjust Medicare payments to hospitals serving "a significantly disproportionate number of low-income patients" in recognition of the fact that those hospitals were incurring greater costs as a result. Under the Medicare statute, "low-income patients" include patients "eligible for" Medicaid. The

Secretary, however, declined to make such an adjustment. 48 Fed. Reg. 39,783 (1983).

In response to the Secretary's failure to provide a DSH adjustment, Congress *directed* the Secretary to develop and publish a DSH definition and identify hospitals that met that definition by December 31, 1984: Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2315(h), codified at 42 U.S.C. § 1395ww note. By July of 1985, the Secretary had still not complied with this congressional mandate, which resulted in a court order directing the Secretary to implement the DSH statutory provision. *See Samaritan Health Center v. Bowen*, 636 F. Supp. 503 (D.D.C. 1985). In 1986, after the Secretary issued extremely narrow DSH criteria (50 Fed. Reg. 53,398-53,400 (1985)), Congress took the extraordinary step, in amending the Social Security Act, of prescribing a specific statutory definition of DSH hospitals.

As amended, the Medicare statute directs the Secretary to furnish an additional payment to hospitals that serve "a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Hospitals qualify under this standard if their "disproportionate patient percentage" exceeds a certain threshold, and the amount of the additional DSH payment for qualifying hospitals depends on the extent to which their disproportionate patient percentage exceeds the

threshold. 42 U.S.C. § 1395ww(d)(5)(F)(v), (vii). The definition of "disproportionate patient percentage"<sup>5</sup> under the Medicare statute uses *eligibility* for Medicaid as a proxy measure for quantifying the low-income status of patients.

On May 6, 1986, the Secretary, without following the advance notice and comment procedures of the APA, issued an interim final regulation to implement the statutory DSH payment (42 C.F.R. § 412.106). See 51 Fed. Reg. 16,772. The Secretary took the position that days would not be counted as Medicaid days under 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), even if they were hospital days attributable to patients "eligible for" Medicaid, if the days were not actually paid for by

<sup>5</sup> ...the sum of—

(I) the fraction (expressed as a percent-age), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under Title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title, and

(II) the fraction (expressed as a percent-age), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(emphasis added).

Medicaid. For example, the Secretary's regulation excluded hospital days attributable to patients eligible for Medicaid if those days were beyond the length-of-stay or day limits<sup>6</sup> established for *payment* purposes by a few state Medicaid agencies (including the agencies in the states in which the members of *amici* associations are located). Therefore, for purposes of calculating the DSH percentage, the Secretary defined Medicaid covered days as only those days for which benefits were actually payable under Medicaid, rather than those days for which a patient was eligible for Medicaid even if Medicaid did not actually pay for those days. See 51 Fed. Reg. 16,777; see also 51 Fed. Reg. 31,460-61. By calculating the DSH percentage so as to exclude days not actually covered by Medicaid, the Secretary reduced the disproportionate patient percentage for health care providers represented by *amici*. The resulting effect has been to deny those providers millions of dollars of additional reimbursement to which they are entitled by the Medicare statute.

<sup>6</sup> The State of Oklahoma, for example, pays hospitals on a *per diem* basis, subject to a day limit. It limits the number of days for which it will make payment to hospitals for inpatient hospital services furnished under the Medicaid program. A hospital does not receive any additional payment for inpatient services provided to a patient hospitalized after the day payment limit is exhausted, even though the patient remained eligible and was covered for other types of services. The state Medicaid agencies in Oregon, Louisiana, Tennessee, and Texas apply similar limiting methodologies.

Over the past few years, the Secretary's DSH regulation has been challenged and ruled invalid by the Fourth, Sixth, Eighth and Ninth Circuits. See *Cabell Huntington Hosp., Inc. v. Shalala* 101 F.3d 984 (4<sup>th</sup> Cir. 1996); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261 (9<sup>th</sup> Cir. 1996); *Deaconess Health Svcs. Corp v. Shalala*, 912 F. Supp. 438 (E.D. Mo. 1995), *aff'd and adopted*, 83 F.3d 1041 (8<sup>th</sup> Cir. 1996); and *Jewish Hosp. Inc. v. Dep't of Health & Human Svcs.*, 19 F.3d 270, 276 (6<sup>th</sup> Cir. 1994). Each of these courts has found the Secretary's DSH regulation to be contrary to the clear language of the Medicare statute as enacted by Congress in 1986. Providers, including those represented by *amici*, have had to repeatedly bring legal actions in the above courts, as well as federal district courts in Texas and Oregon<sup>7</sup> and in *Anadarko* in Oklahoma, to challenge the Secretary's hostile attitude to the concept of DSH adjustments and her refusal, from the very beginning, to follow the Congressional mandate.

As further evidence of her hostility to the DSH adjustment and the will of Congress, the Secretary has published instructions to fiscal intermediaries purporting to

<sup>7</sup> *Incarnate Word Health Svcs. Fort Worth Healthcare Corp. v. Shalala*, CIV-3:95-851-R (N.D. Tex. July 25, 1997); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, No. 94-754-HA (D. Or. May 30, 1997).

implement the recent circuit court rulings, but which unlawfully restrict those rulings. For example, after the Sixth and Eighth Circuits' decisions, the Secretary issued instructions that were directly at odds with the court holdings. See Appendix B, at App. 2. Further, despite repeated judicial declarations that her regulation was contrary to the Medicare statute, the Secretary has continued to direct her intermediaries to deny provider requests for reopening of a cost report to correct the DSH adjustment.<sup>8</sup> By asserting that intermediary denials of reopenings (including denials pursuant to her directives) are not reviewable by any administrative or judicial body, the Secretary has effectively been able to avoid her statutory obligation to fully reimburse DSH providers.

In supposed acquiescence to the court decisions, the Secretary issued HCFA Ruling 97-2 on February 27, 1997.<sup>9</sup> This ruling provided that HCFA must calculate DSH adjustments in keeping with the law as declared by the court decisions, but that the ruling only applied prospectively to

<sup>8</sup> The Secretary takes this position even though her own regulations state that reopenings are mandatory if an intermediary is advised that a final reimbursement determination had been made contrary to law. See footnote 10, *infra*.

<sup>9</sup> HCFA, the Health Care Financing Administration, is an office within the Department of Health and Human Services which serves as the Secretary's agent.

cost reporting periods beginning on or after February 27, 1997 or to cost reports not yet finalized as of that date. As for previously settled cost reports periods still within the three-year reopening period, the ruling forbid fiscal intermediaries from reopening the DSH adjustment to conform to the Circuit Court decisions.

**II. The Secretary's Continuing Hostility To The DSH Congressional Mandate Is Evidenced By Her Recent Actions In *Anadarko*, Where She Predicates Her Scheme For Precluding Corrective DSH Adjustments On Being Able To Arbitrarily Declare And Pursue A No-Reopening Policy That Is Not Reviewable By Any Administrative Or Judicial Body.**

On April 13, 1998, the federal district court in Oklahoma granted the *Anadarko* plaintiffs' motion for summary judgment. In its order, the court held that the DSH regulation was void *ab initio*, that the Secretary was under a congressionally imposed obligation to issue a regulation in accordance with the Medicare statute, and that HCFA Ruling 97-2 did not meet the Secretary's obligation to comply with applicable law. In light of these holdings, the court retained jurisdiction over the case and ordered the Secretary to rescind the DSH regulation and to report quarterly to the court on the

status of rescission and of any successor regulation. See Appendix C, at App. 8.

On July 13, 1998, the Secretary filed her first quarterly report with the court. See Appendix D, at App. 26. Although the court had ordered the Secretary to document the status of *rescission* of the DSH regulation and implementation of a successor regulation, the Secretary's report made no reference to rescission. Instead, the report referred to the Secretary's May 8, 1998, Notice of Proposed Rulemaking ("NPRM"). This NPRM purports to *revise* the prior DSH regulation to include in the calculation of the DSH percentage all days on which a patient was eligible for Medicaid, regardless of whether particular items or services were covered or paid for under an approved state Medicaid plan. NPRM, 63 Fed. Reg. 25,576 at 25,595, 25,606. However, this *revised* regulation applies only to cost reporting periods beginning on or after October 1, 1998. The Secretary states in the NPRM that HCFA Ruling 97-2 would continue to apply to cost reporting periods beginning before October 1, 1998. The Secretary's proposed rule has been finalized. July 31, 1998 Final Rule, 63 Fed. Reg. 40,954, 40,984-85.

In other words, according to the Final Rule, the DSH regulation invalidated by the *Anadarko* court, as well as

federal courts in the jurisdictions in which *amici* members are located, will continue to govern the calculation of the DSH adjustment unless the provider's cost report was not yet settled by its fiscal intermediary as of February 27, 1997, or the provider had an appeal from a cost report determination pending as of February 27, 1997. 63 Fed. Reg. at 25,595; 63 Fed. Reg. at 40,985. The new regulation does not recognize that the prior interpretation was invalid. On the contrary, it specifically preserves the effect of the prior invalid DSH regulation by maintaining HCFA Ruling 97-2 in place and thus preventing, even within the three-year time period for reopening, the reopening of cost reports involving erroneously calculated DSH adjustments settled prior to February 27, 1997. Clearly, the Secretary has continued to utilize her control over the reopening process, and the lack of review thereof, to deny the reimbursement adjustments that she has been ordered, by Congress and the courts, to make.

Based on the Secretary's failure to rescind the invalid regulation and her decision to limit the applicability of the new regulation to prospective cost reporting periods, the *Anadarko* plaintiffs filed a motion on August 14, 1998, seeking an order enforcing the court's decision. As one means of enforcing the court's prior order, plaintiffs asked the court to order the Secretary to inform her fiscal

intermediaries that the DSH regulation had been declared void since its inception and that determinations made pursuant to it were inconsistent with applicable law.

In her September 17, 1998, response to plaintiffs' motion, the Secretary argued that the court could not order her to instruct her intermediaries about the invalidity of the DSH regulation because doing so would be tantamount to the court ordering reopening of cost reports determinations premised on the invalid regulation.<sup>10</sup> The Secretary insisted that the court cannot issue such an order because her decision not to reopen cost reports is unreviewable.<sup>11</sup>

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<sup>10</sup> Under 42 C.F.R. § 405.1885(a), a final determination, whether made by an intermediary, a hearing officer, the PRRB, or the Secretary herself, may be "reopened" by the decision-maker either on the decision-maker's own initiative or at the request of the provider, to revise any matter at issue in the decision. Any request to reopen must be made within three years of the date of the decision. Thus, subsection (a) of 42 C.F.R. § 405.1885 governs reopenings that are discretionary, but subject to certain standards. Subsection (b) provides for mandatory reopening. A determination made by an intermediary *must* be reopened if, within the three year time period, HCFA notifies the intermediary that the intermediary's determination was inconsistent with the applicable law, regulations, or general HCFA instructions. Clearly, any determination made pursuant to a DSH regulation which was invalid since its inception would have been contrary to applicable law.

<sup>11</sup> Incredibly, the Secretary also argued that "retroactivity" was not required because, she asserted, her regulation was the law in the Tenth Circuit until February 27, 1997, the date that she issued HCFA Ruling 97-2 in purported acquiescence with prior court rulings invalidating the regulation. With this assertion, she attempts to write the *ab initio* portion

Oral argument on the *Anadarko* plaintiffs' motion was heard on September 25, 1998. The court has not yet issued a decision.

### III. The Secretary's Recent Actions In Response To The *Anadarko* Decision Illustrate The Danger To The Rule Of Law Posed By Her Desire To Shield Her Reopening Determinations From Judicial Review.

Through her actions in response to the *Anadarko* court order invalidating her DSH regulation *ab initio*, that is, her refusal to rescind the regulation, her refusal to notify her fiscal intermediaries of the court decision invalidating the regulation and her refusal to reopen cost reports settled under the invalid regulation, the Secretary seeks to preserve absolute and unfettered discretion to deny providers the DSH adjustments which they are statutorily entitled to receive. When confronted with the inherent inconsistency between her actions and the court's declaration that her DSH regulation has been illegal since its inception in 1986, the Secretary asserts that the court has no power to order her to rescind the regulation or to notify her agents of its illegality because any such action would ultimately lead, *under the*

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of the *Anadarko* "void *ab initio*" declaration completely out of the picture.

*terms of her own reopening regulation*, to reopening of cost reports. The court does not have this power, she posits, because the reopening process is solely within her purview and not subject to judicial scrutiny regardless of how arbitrarily she may administer the regulatory reopening process.

Further, the Secretary argues, allowing review of reopening denials would violate the 180-day time limit by which providers must appeal a final reimbursement determination. As fully argued in the AHA brief, pp. 10-14, however, the Secretary's own regulation<sup>12</sup> contemplates that adjustments to reimbursement decisions will occur long after deadline for appeals. Such regulation also "evidences the Secretary's conclusion that the need for accuracy in the reimbursement determination should override the finality concerns . . .". AHA brief, p. 11. The Secretary's reopening rules clearly contemplate reopenings of determinations that

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<sup>12</sup> 42 C.F.R. § 405.1885. See footnote 10, *supra*. The "parade of horrors" argument (*i.e.*, if providers have their way, no decision by the Secretary would ever be final) set forth by the Secretary in the *Anadarko* briefing is disingenuous. As the Secretary herself recognizes, the three-year time period for reopenings is a built-in limitation. 42 C.F.R. § 405.1885. See *Memorial Hospital v. Sullivan*, 779 F. Supp. 1410, 1412 (D.D.C. 1991) ("the Secretary's fear of destroying the finality of decisions is not present here. Under 42 C.F.R. § 405.1885(a), a provider must reopen . . . within three years . . . and there is no fear that the decision . . . will spawn a plethora of such requests.").

have been made contrary to applicable law. At the very least, in the jurisdictions where federal courts have invalidated the DSH regulation as contrary to the 1986 Congressional mandate, the Secretary must accept those court decisions as the rule of law. She cannot be allowed to utilize the 180-day appeal deadline as grounds for asserting that a court is powerless to enforce the rule of law inherent in its own decision. She cannot avoid consequences of the court's decision on the grounds that enforcement would interfere with what she claims is her unfettered discretion to direct intermediaries to deny reopening requests, even where the determination sought to be reopened was rendered contrary to law. This is indeed a dangerous argument, which subjects the rule of law to the Secretary's arbitrary and capricious whim.

If the Secretary is permitted to act as she is attempting to do in *Anadarko*, then no final determination can ever be reopened, even if its legal underpinnings are judicially declared void from their inception as violative of the Congressional mandate, unless the Secretary decides in her unfettered discretion that she (or fiscal intermediaries acting at her direction) wish to allow reopening. The Secretary's unsound reasoning offered in *Anadarko* makes meaningless the standards purporting to govern reopening decisions as set

forth in her own reopening regulation, and allows the Secretary to ignore such standards with impunity.

#### **IV. In Her Desire To Further Preclude Reopenings To Correct Determinations Made Pursuant To The Invalidated DSH Regulation, The Secretary Appears To Be Restricting Reopenings For Previously Allowable Adjustments.**

The Secretary's recent actions in *Anadarko* establish that she is absolutely determined not to correct her prior erroneous, illegal determinations of DSH adjustments, and that she believes she can accomplish her goals by relying on her unfettered discretion over the reopening process and her unreviewable instruction not to reopen those determinations. Her dedication to this contention has even caused her to take the position that reopenings will no longer be allowed to correct errors for which reopenings had previously been routinely allowed, such as adjusting Medicaid paid days, which all parties agreed should have been part of the DSH calculation under any interpretation of the statute, but which were erroneously calculated.<sup>13</sup> Thus, the Secretary is apparently willing to arbitrarily restrict the reopening process

<sup>13</sup> Although asked over a year ago to confirm, in writing, whether it really intends such an inexplicable change in policy, HCFA has still failed to clarify its interpretation. See Appendix E, at App. 29.

in order to preserve the unlawful effect of her invalidated DSH regulation. The Secretary knows that, under her own regulations and under HCFA Ruling 97-2, a proper reopening of the Medicaid paid days figure would allow a provider to insist that the DSH adjustment be calculated in accordance with the law as enacted by Congress. Rather than compensating providers according to the law, the Secretary seeks to arbitrarily restrict the reopening process to prevent a provider from securing a new final DSH determination that would be subject to HCFA Ruling 97-2 and the Secretary's own view of the appeal process.<sup>14</sup>

If the Secretary's reopening decisions are entirely unreviewable, then, as the *Anadarko* case demonstrates, the Secretary can continue to arbitrarily preclude reopenings which do not secure recoupment for the Medicare program, even when the determinations for which review is sought are

<sup>14</sup> The Secretary herself has provided for appeals from revised Notices of Program Reimbursement issued pursuant to a reopening. 42 C.F.R. § 405.1889. That is, once specific reimbursement findings are reopened, a provider has issue-specific appeal rights. The provider can appeal to the PRRB the result of the reopening, including any adjustment made in a revised NPR. *Id.* Thus, if a cost report is reopened to adjust *Medicaid-paid* days, a new DSH calculation/adjustment would result. The provider could pursue an appeal of that new calculation/adjustment to add in *Medicaid-eligible* days because the appeal would be issue specific; *i.e.*, related to the matter of the new calculation/adjustment.

contrary to law. As the AHA notes, "while this approach may be financially beneficial to the government, it is clearly inconsistent with the Secretary's obligations under the Medicare statute and is patently unfair to providers that have served Medicare beneficiaries with the expectation of payment in accordance with the law." AHA brief, p. 19.

### CONCLUSION

*Amici* urge the Court to consider the Secretary's actions and positions taken in *Anadarko* for the bright light they shed on the real-world effect of barring administrative and judicial review of reopening decisions. The Secretary cannot be allowed to claim unfettered discretion over the reopening process and thereby avoid the consequences of judicial decisions, which have found her interpretation of the Medicare statute to be contrary to law. To protect the rule of law, the Court should adopt the position of petitioner, as supported by AHA *amici*, and find PRRB and/or federal district court jurisdiction to review a denial of reopening requests.

Respectfully submitted this 22<sup>nd</sup> day of October, 1998.

DAVID B. ROBBINS  
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 SANFORD E. PITLER  
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 Washington State Hospital  
 Association  
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 and Healthcare Organizations  
 Certus Corporation

Apr. 1

Diana L. Gustin

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October 12, 1998

VIA FACSIMILE AND FEDERAL EXPRESS NO. 35191213

Sanford B. Pizer

Bennett Higdon &amp; Lusk

999 Third Avenue, Suite 2000

Seattle, Washington 98101

**APPENDIX A****WRITTEN CONSENT OF PETITIONER**

Re: Your Home Visiting Nurse Service Inc. v.  
 Secretary HHS  
 Case No. 97-1489  
 Amicus Curiae Brief

Dear Mr. Pizer:

The information you requested is being copied and will be sent to you by Federal Express today. My client agrees to your participation in regard to the above-captioned matter. Please call me at the letter as written permission.

The telephone number for Lisa Blatz is (202) 341-4225.

If you have any questions, please feel free to contact my office.

Sincerely,

Diana L. Gustin

cc: Mr. Barry Lewis, NCHS

App. 1

Diana L. Gustin

Attorney at Law

11 Town Square • Post Office Box 1359 • Norris, Tennessee 37828

Telephone (423) 494-3000 • Telecopier (423) 494-3003

October 12, 1998

VIA FACSIMILE AND FEDERAL EXPRESS NO. 3838128136

Sanford E. Pitler

Bennett Bigelow & Leedom, P.S.

999 Third Avenue, Suite 2150

Seattle, Washington 98104-4036

Re: Your Home Visiting Nurse Service Inc. v.  
Secretary HHS  
Case No. 97-1489  
Amicus Curiae Brief

Dear Mr. Pitler:

The information you requested is being copied and will be sent to you via Federal Express today. My client agrees to your participation in regard to the above-captioned matter. Please consider this letter as written permission.

The telephone number for Lisa Blatt is (202) 5414-2251.

If you have any questions, please feel free to contact my office.

Sincerely,

/s/

Diana L. Gustin

cc: Ms. Betty Leake, YHVNS



App. 2

DEPARTMENT OF HEALTH & HUMAN SERVICES  
FKA122

Health Care Financing Administration  
6325 Security Boulevard  
Baltimore, MD 21207-5187

OCT 20 1994

Director,  
Bureau of Program Policy

Effectuating Sixth Circuit Decision in Jewish Hospital

HCFA Regional Office,  
Atlanta

As you may be aware Jewish Hospital had contested HCFA's interpretation of the regulations at 42 CFR 412.106 concerning the calculation of disproportionate share payments (DSH). In calculating payments HCFA determined the percentage of low income patients as the number of inpatient days attributable to beneficiaries who were entitled to both Medicare Part A and Federal Supplemental Security Income divided by the total number of Medicare patient days, plus the number of paid Medicaid patient days divided by total patient days. Previously, medicaid patient days were interpreted as those days for which a patient qualified for and received payments for service. HCFA has stood by this policy as outlined in the September 3, 1986 Federal Register Vol.51, No. 170, 31460.

This case was decided in favor of Jewish Hospital on March 18, 1994, by the United States Court of Appeals for the Sixth Circuit. Recently the Sixth Circuit has denied the rehearing request, thereby leaving intact the decision in  
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Jewish Hospital Inc. v. Secretary of Health and Human Services, 19 F. 3d 270 (1994).

As a result, you will need to contact the fiscal intermediaries servicing hospitals within the jurisdiction of the Sixth Circuit (Kentucky, Michigan, Ohio and Tennessee) to notify calculations for the affected hospitals.

1. In the future, DSH calculations will be determined using the Court's methodology. This means that the calculation of the DSH adjustment would include inpatient hospital days which would have been paid by Medicaid but for State coverage limitations on such days. The calculation would not include patient days which are not within the limited service packages for illegal aliens (emergency services), qualified low-income pregnant women (services related to pregnancy), or COBRA continuation beneficiaries. In addition, intermediaries should be made aware that the decision should be effectuated by compliance with the narrow issue considered by the Court, i.e. intermediaries should not add to the calculation any patient days which would not have been included because of reasons other than number-of-day coverage limits.
2. Presently, use the court's methodology to recompute past DSH payments for those cost years for which a Notice of Program Reimbursement has not, as yet, been issued or it has been issued and there is a

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jurisdictionally proper appeal.

3. We will deny any requests for the reopening of fiscal periods for which final payment has been made and the time has passed for simple reconsideration or appeal.

The above policies will go into effect from July 1, 1994, the beginning of the first quarter following the Sixth Circuit decision. If you have any further questions regarding this issue please contact Anne Tayloe at (410) 966-4546.

/s/

Thomas A. Ault

App. 5

DEPARTMENT OF HEALTH & HUMAN SERVICES  
FKA-31

Health Care  
Financing Administration  
MEMORANDUM

FROM: Director SEP 30 1996  
Bureau of Policy Development

SUBJECT: Effectuating Eighth Circuit Decision in  
Deaconess Health Services Corporation

TO: HCFA Regional Office,  
Chicago  
Dallas  
Denver  
Kansas City

As you may be aware, Deaconess Health Services Corporation challenged HCFA's interpretation of the regulations at 42 CFR 412.106 concerning the calculation of disproportionate share payments (DSH). In calculating those payments, HCFA determined the percentage of low income patients as the number of inpatient days attributable to beneficiaries who were entitled to both Medicare Part A and Federal Supplemental Security Income divided by the total number of Medicare patient days, plus the number of paid Medicaid patient days divided by total patient days. Deaconess challenged HCFA's determination of Medicaid patient days. Previously, Medicaid patient days were interpreted as those days for which a patient qualified for and received Medicaid payments for inpatient hospital service. HCFA has stood by this policy as outlined in the September 3, 1986 Federal Register Vol. 51, No. 170, 31460.

App. 6

This case was decided in favor of Deaconess Health Services Corporation on May 22, 1996, by the United States Court of Appeals for the Eighth Circuit. In a short opinion, the Eighth Circuit affirmed the District Court decision in Deaconess Health Services Corporation v. Secretary of Health and Human Services, 83 F.3d 1041 (1996). Therefore, the Secretary is bound by this decision for providers within the jurisdiction of the Eighth Circuit.

As a result, you will need to contact the fiscal intermediaries servicing hospitals within the jurisdiction of the Eighth Circuit (Arkansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota).

1. In the future, DSH adjustments for hospitals within the jurisdiction of the Eighth Circuit will be determined using the methodology which resulted from the decision in Jewish Hospital Inc. v. Secretary of Health and Human Services, 19 F.3d 270 (1994). This means that the calculation of the DSH adjustment would include inpatient hospital days which would have been paid by Medicaid but for State coverage limitations on such days. The calculation would not include patient days which are not paid by Medicaid for other reasons, including patient days which are paid in full by third parties, days paid by Medicare Part A, and patient days which are not within the limited service packages for illegal aliens (emergency services), qualified low-income pregnant women (services related to Pregnancy), or COBRA continuation beneficiaries. In sum, intermediaries should be made aware that the decision should be effectuated by compliance with the narrow issue considered by the Court, and not more broadly; i.e., intermediaries should not add to the calculation any patient days which would not have been included because of reasons other than number-of-day coverage limits.

2. Presently, use this methodology to recompute past DSH payments for those cost years for which a Notice of Program Reimbursement (NPR) has not, as yet, been issued; or for those years in which the NPR has been issued and there is a jurisdictionally proper appeal.

3. Deny any requests for the reopening of fiscal periods for which final payment has been made and the time has passed for simple reconsideration or appeal.

The above policies will go into effect from July 1, 1996, the beginning of the first quarter following the Eighth Circuit decision. If you have any further questions regarding this issue, please contact Anne Rudolph at (410) 786-4546.

/s/

Thomas A. Ault

IN THE UNITED STATES DISTRICT COURT FOR THE  
WESTERN DISTRICT OF OKLAHOMA

ANADARKO MUNICIPAL  
HOSPITAL, et al.

Plaintiffs,

No. CIV-97-288-A

APPENDIX C

DONNA E. SHALALA,  
Secretary  
OF HEALTH  
SERVICES

**ANADARKO MUNICIPAL HOSPITAL v.  
SHALALA, CIV-97-288-A**

**COURT ORDER DATED APRIL 13, 1998**

Defendant.

ORDER

Defendant seeks an entry of judgment awarding plaintiff all of the requested monetary claims for which they provide documentary proof. Having the duty to read this case by motion to dismiss, Plaintiff seeks a motion for summary judgment awarding their monetary claims and declaring 42 C.F.R. 441.210 void or null. Defendant responds, arguing that all of plaintiff's claims should be denied because of the proposed entry of judgment and the issuance of HCA Ruling 97-2. A hearing on these motions was held on March 3, 1998. The parties were given until April 6,

IN THE UNITED STATES DISTRICT COURT FOR THE  
WESTERN DISTRICT OF OKLAHOMA

ANADARKO MUNICIPAL  
HOSPITAL, et al.

Plaintiffs,

v.

DONNA E. SHALALA,  
SECRETARY DEPARTMENT  
OF HEALTH AND HUMAN  
SERVICES,

Defendant.

No. CIV-97-288-A

**ORDER**

Defendant seeks an entry of judgment awarding plaintiffs all of their requested monetary claims for which they provide documentary proof, hoping thereby to rend this case by mootng its issues. Plaintiffs seek a motion for summary judgment awarding them their monetary claims, and declaring 42 C.F.R. § 412.106 void *ab initio*. Defendant responds, arguing that all of plaintiffs' claims should be moot because of the proposed entry of judgment and the issuance of HCFA Ruling 97-2. A hearing on these motions was held on March 3, 1998. The parties were given until April 6,

1998, to file optional supplemental briefs. Both parties have done so.

### Procedural History

Plaintiffs, a group of 29 hospitals, brought suit for monetary and declaratory relief against defendant, challenging the validity of defendant's interpretation of 42 U.S.C. § 1395ww(d)(5)(F) in C.F.R. § 412.106(b)(4)(1998). The Provider Reimbursement Review Board ("PRRB") granted an expedited judicial review of the issue. On June 29, 1997, this Court administratively closed this action until July 25, 1997, to allow the parties to obtain a final determination of the action.<sup>1</sup> On September 23, 1997, the parties requested that the Court reopen the action.

Defendant admits that plaintiffs are entitled to relief under a revised interpretation of 42 U.S.C. § 1395ww(d)(5)(F). Although defendant has not vacated or rescinded the challenged regulation, 42 C.F.R. § 412.106, it has published a Health Care Financing Administration ("HCFA") Ruling 97-2 in an attempt to comply with four circuit court decisions that have found 42 C.F.R. § 412.106(b)(4) an impermissible interpretation of the statute.

<sup>1</sup> The Order was subsequently extended to September 23, 1997.

Defendant seeks an entry of judgment to recalculate the Medicare disproportionate share payment adjustment for all requested categories of payment by plaintiffs. Plaintiffs would merely be required to submit documentary proof of their entitlement to payment.

Plaintiffs' motion for summary judgment was filed the same day as defendant's motion for entry of judgment.

### Undisputed Facts

Four circuit courts have found 42 C.F.R. § 412.106(B)(4) directly contradicts the clear language of 42 U.S.C. § 1395ww(d)(5)(F), which obliges payment for those days a patient would be eligible for coverage under the state Medicaid plan, rather than entitled to coverage. Eligibility refers to the patient's right to receive funds under the Medicaid plan, rather than his actual receipt of funds under the plan. See Cabell Huntington Hospital, Inc. v. Shalala, 101 F.3d 984 (4<sup>th</sup> Cir. 1996); Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261 (9<sup>th</sup> Cir. 1996); Deaconess Health Serv. Corp. v. Shalala, 912 F.Supp. 438 (E.D.Mo. 1995), aff'd and adopted, 83 F.3d 1041 (8<sup>th</sup> Cir. 1996); Jewish Hospital, Inc. v. Department of Health & Human Serv., 19 F.3d 270, 276 (6<sup>th</sup> Cir. 1994). See also Incarnate Word Health Services Fort Worth Healthcare Corp. v. Shalala, CIV-3:95-851-R (N.D. Tex. July 25, 1997);

Legacy Emanuel Hospital & Health Center v. Shalala, Nos. 94-754-HA (D.Or. May 30, 1997). Plaintiffs' Motion for Summary Judgment, Attachments I, J. In response to this litigation, HCFA issued HCFA Ruling 9702 on February 27, 1997. This ruling provides that HCFA will count those days a patient was eligible for Medicaid regardless of whether the hospital received payment for those days. However, this calculation is prospective only and will be applied to those hospitals who have or have had an appeal pending regarding HCFA's prior interpretation.

#### **Entry of Judgment**

Defendant stipulates that it will calculate the reimbursement in accordance with plaintiff's request, which it recognizes is consistent with the four circuits' rulings. Plaintiffs admit that their claims for monetary relief are now moot.

By affidavit of Nancy Edwards, defendant affirms that the four requested categories of days identified by plaintiff will be reimbursed. Defendant's Opposition to Plaintiffs' Motion for Summary Judgment, Ex. 1. Plaintiffs must submit documentary proof for all of their requests to defendant prior to recovering payments. Plaintiffs contend that HCFA Ruling 97-2 contains impermissible language, and that the entry of judgment does not address all of

plaintiffs' claims. As discussed below, defendant's entry of judgment does not moot plaintiffs' remaining claims, and thus the motion is DENIED.

#### **Summary Judgment**

Summary judgment is appropriate if the pleadings and affidavits show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). "[A] motion for summary judgment should be granted only when The moving party has established the absence of any genuine issue as to a material fact." Mustang Fuel Corp. v. Youngstown Sheet & Tube Co., 561 F.2d 202, 204 (10<sup>th</sup> Cir. 1977).

#### **A. Mootness**

A court lacks subject matter jurisdiction if there is no live case or controversy. F.E.R. v. Valdez, 58 F.3d 1530, 1532-1533 (10<sup>th</sup> Cir. 1995). Defendant bears a heavy burden of demonstrating mootness. United States v. W.T. Grant Co., 345 U.S. 629, 633 (1953). "The touchstone of the mootness inquiry is whether the controversy continues to 'touch [] the legal relations of parties having adverse legal interests . . .'" Cox v. Phelps Dodge Corp., 43 F.3d 1345, 1348 (10<sup>th</sup> Cir. 1994). "It is well established that what makes a declaratory judgment action 'a proper judicial resolution of a case or

controversy rather than an advisory opinion – is [] the settling of some disputes which affects the behavior of the defendant toward the plaintiff.” Green v. Branson, 108 F.3d 1296, 1299 (10<sup>th</sup> Cir. 1977) (internal quotation omitted). A plaintiff must show a good chance of being likewise injured in the future. Id. At 1300.

The Court finds a continuing live case or controversy. The PRRB certified the question of the regulation's validity as well as HCFA's application of the regulation to this Court for review. Plaintiff's Motion for Summary Judgment, Attachment R. Although HCFA has agreed to recalculate the payments to plaintiffs, it has not agreed to invalidate its prior regulation. The Court finds that plaintiffs' declaratory judgment claims are not mooted by HCFA Ruling 97-2 nor by defendant's agreement to recalculate their claims.

The facial validity of the regulation is still a live controversy, unless (1) there is no reasonable expectation that the alleged violation will recur, and (2) interim relief has completely and irrevocably eradicated the effects of the alleged violation. City of Mesquite v. Aladdin's Castle, Inc., 455 U.S. 283, 289 (1982). See also City of New Haven, Conn. V. United States, 809 F.2d 900 (D.C. Cir. 1987) (holding request for fee waiver was mooted by agency's change in position; however, question of the facial validity of

the regulation was a live controversy). “[A]fter years of litigation challenging an administrative regulation, an agency would be able to moot a given lawsuit by promulgating a new regulation.” Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d 1435, 1450 n. 27 (11<sup>th</sup> Cir. 1987), cert. Denied, 485 U.S. 1020 (1988). See e.g. Nader v. Volpe, 475 F.2d 916, 917 (10<sup>th</sup> Cir. 1973) (because the violation is capable of repetition, yet evading review, action not moot where agency order expires or is withdrawn).

Here, there is a reasonable expectation that the improper interpretation may be applied in the future, and HCFA Ruling 97-2 does not provide complete relief. Because HCFA Ruling 97-2 is not promulgated pursuant to the Administrative Procedures Act, it is not a formal regulation. Although defendant argues it is a final agency order, it may be rescinded quickly and easily by a subsequent order solely with HCFA's discretion. See e.g. Arkansas Medical Soc. Inc. v. Reynolds, 6 F.3d 519, 528 (8<sup>th</sup> Cir. 1993) (holding DHS reserves the right to set reimbursement rates, thus, it clearly has not met its heavy burden to demonstrate mootness). As discussed below, HCFA has been loath to properly interpret the statute and its Ruling contains impermissible language. The Ruling contains language that continues to favor entitlement over eligibility

as the criterion. Id.; see also Incarnate Word Health Services Forth Worth Healthcare Corp. v. Shalala, CIV-3:95-851-R (N.D. Tex. July 25, 1997). Further, the Ruling does not provide complete relief as it is prospective only. The Court recognizes that the issue of reopening finalized reimbursement orders is not before the court. However, this issue reflects the inadequacy of HCFA's interim order for mootness purposes. Defendant has not yet rescinded the regulation even though HCFA Ruling 97-2 was issued over a year ago. HCFA Ruling 97-2 does not recognize that its prior interpretation was invalid. See e.g. Sierra Club v. Cargill, 732 F.Supp. 1095, 1098 (D.Colo. 1990) (holding agency's determination that former standard was legal although voluntarily ceased its interpretation provided no guarantee that it would not revert to improper interpretation). Plaintiffs' Motion for Summary Judgment, Attachment K. Rather, HCFA continues to assert that it was a reasonable interpretation. Id.; see also Alaniz v. Office of Personnel Management, 728 F.2d 1460, 1465 (Fed.Cir. 1984) ("It is clear that no deference is due to an agency interpretation fashioned for the purposes of litigation").

Defendant is under a Congressional obligation to issue a regulation in accordance with the statute. The current regulation is void *ab initio* as discussed below. See e.g.

Dixon v. United States, 381 U.S. 78, 70 (1965) (a regulation contrary to statute is a mere nullity). Defendant's continuing hostility towards this interpretation, along with its delay in rescinding the regulation, support plaintiffs' argument that the invalid interpretation may recur. Accordingly, plaintiffs' declaratory judgment claims are not moot.

Even assuming defendant's issuance of Ruling 97-2 somehow moots plaintiffs' declaratory judgment claims, their claims fall within two exceptions of the mootness doctrine. There are three exceptions to the mootness doctrine: (1) failure to rule on an issue will have collateral legal consequences, (2) the mooted issue is capable of repetition, yet evading review, or (3) a party has taken all steps necessary to perfect the appeal and to preserve the status quo before the dispute becomes moot. See e.g. B&B Chemical Co. v. United States E.P.A., 806 F.2d 987, 990 (11<sup>th</sup> Cir. 1986).

Defendant contends that there is no reasonable expectation that it will rescind HCFA Ruling 97-2 and apply an interpretation contrary to the four circuits' rulings. Defendant's history of hostility toward properly interpreting the statute weighs in favor of a reasonable expectation defendant will once again improperly interpret the statute.

Prior to October 1, 1983, hospital services were reimbursed under Medicare on a reasonable cost basis. 42 U.S.C. § 1395f(b). After October 1, 1983, Congress adopted a prospective payment system ("PPS") for reimbursement. This system is based upon a predetermined rate set on a per-discharge basis subject to certain payment adjustments. 42 U.S.C. § 1395ww(d)(5)(F). Nonetheless, the Secretary declined to make the adjustment to a new basis. 48 Fed.Reg. 39,783 (1983). Congress directed the Secretary by December 31, 1984, to develop and publish a disproportionate share definition and identify hospitals that met the definition. 42 U.S.C. § 1395ww note; Deficit Reduction Act, Pub.L. 98-369, § 2315(h), 98 Stat. 494, 1080 (1984). by July 1985, the Secretary had not yet complied with this mandate. A court order was issued directing the Secretary to implement the adjustment. See Samaritan Health Center v. Heckler, 636 F.Supp. 503, 517-18 (D.D.C. 1985). Subsequently, Congress amended the Medicare statute to prescribe a statutory definition of disproportionate share hospitals ("DSH"). Consolidated Omnibus Reconciliation Act of 1985, Pub.L.No. 990272, § 9105 (1986). The Medicare statute directs the Secretary to make an add-on payment for PPS hospitals that serve "a significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). On May 6,

1986, the Secretary adopted regulations implementing the statute and finding that payment would be made only for those days that the patient was entitled to state Medicaid reimbursement, i.e., the days the hospital was actually reimbursed under the state plan. 42 C.F.R. § 412.106(b)(4) (1998). This procedural history has been cited in support for the theory that defendant has been hostile towards the statutory interpretation. See Jewish Hospital, 19 F.3d at 275; Samaritan Health Center, 636 F.Supp. at 517. The Court finds ample evidence that defendant's invalid interpretation is capable of repetition, yet evading review.

Moreover, this action falls within an alternative mootness exception regarding collateral legal consequences. Ortho Pharmaceutical Corp. v. Amgen, Inc., 882 F.2d 806, 810 (3<sup>rd</sup> Cir. 1989). See generally, Sibron v. New York, 3392 U.S. 40, 53-57 (1968). See also Sule v. Warden, ADX Florence Colorado, 133 F.3d 933 (table, text in Westlaw) 1998 WL 10240 (10th Cir. Jan. 13, 1998) (unpublished disposition cited as persuasive authority pursuant to Tenth Circuit Rule 36.3). Without a ruling regarding the invalidity of the regulation in this district, defendant could inch back to an interpretation contrary to the regulation. The status of the appropriate interpretation in this district would be left within the defendant's discretion. See Arkansas Medical, 6 F.3d at

528. As the Ruling does not apply retroactively and is not a final agency order under the APA, the plaintiffs and other hospitals would be precluded from seeking judicial review of the Ruling regarding prior disallowed claims. The administrative process permitting such a review is a time-consuming and expensive procedure. The Court finds that its failure to rule on the regulation's invalidity would have collateral legal consequences for these and other plaintiffs. Thus, plaintiffs' declaratory judgment claims are not moot.

#### B. Subject Matter Jurisdiction

Next, defendant contends that this Court lacks subject matter jurisdiction over this case. Judicial interpretation of the Medicaid statute must be certified by the PRRB. Once certified, the Court is not limited in fashioning appropriate remedies in this case. Pursuant to Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d at 1450 n. 27, 42 U.S.C. §1395oo does not limit the Court's power to fashion appropriate remedies once judicial review is certified by the PRRB. HCFA's attempt to moot claims regarding this regulation through Ruling 97-2 came after the PRRB certified the regulation's validity to this Court. HCFA cannot now maintain that its Ruling modifies the regulation and simultaneously prevents the plaintiffs from attacking its

contents. The Court finds it has jurisdiction over plaintiffs' claims.

#### C. HCFA Ruling 97-2

According to a Northern District of Texas case, certain language in HCFA Ruling 97-2 is impermissible and creates ambiguity regarding the definition of eligibility:

claims by hospitals must 'meet all other applicable requirements,' which include the hospitals verifying with the State 'that a patient was **eligible for Medicaid (for some covered services)** during each day of the patient's inpatient hospital stay.' . . . This Court has clearly stated that the relevant test for days included in the Medicaid low-income proxy calculation is eligibility for Medicaid, **not service coverage**. Insofar as HCFA Ruling 97-2 requires proof of service coverage as proof of eligibility, it contradicts this Court's two Orders in this case and the holdings of the four Circuit Courts that have ruled on this issue.

Incarnate Word Health Services Fort Worth Healthcare Corp. v. Shalala, CIV-3:95-851-R (N.D. Tex. July 25, 1997). The Court agrees. HCFA Ruling 97-2 does not completely eliminate any controversy or ambiguity in defendant's interpretation of 42 U.S.C. §1395ww(d)(5)(F). The Court finds defendant's new interpretation is based on four circuits' rulings, not because HCFA recognizes the regulation's

invalidity. Alaniz, 728 F.2d at 1465 (holding agency interpretation not entitled to deference where issued because of litigation). Accordingly, HCFA Ruling 97-2 does not satisfy its statutory mandate, and contains impermissible language.

#### D. Void Ab Initio

Four circuit courts and two district courts have ruled that 42 C.F.R. §412.106(b)(4) is an impermissible interpretation of 42 U.S.C. §1395ww(d)(5)(F). This Court agrees. The standard of review of an agency interpretation is governed by Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 843 (1986). First, the issue is whether by looking first to the language of the statute and then if necessary to legislative history, Congress has directly spoken to the precise question at issue. Id. If Congressional intent is clear, the Court and the Agency must give effect to Congressional intent. Id. If Congress has not directly addressed the issue, i.e. the statute is silent or ambiguous, the issue is whether the agency's interpretation is a permissible construction of the statute. Id.

Pursuant to 42 U.S.C. §1395ww(d)(5)(F)(i):

For discharges ..., the Secretary shall provide..., for an additional payment amount for each ... hospital which—

(1) serves a significantly disproportionate number of low-income patients...

A hospital "serves a significantly disproportionate number of low income patients" if the hospital has a disproportionate patient percentage which is defined as:

(I) the fraction..., the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter..., and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this subchapter, and

(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter, and the denominator

of which is the total number of the hospital's patient days for such period.

42 U.S.C. §1395ww(d)(5)(F)(iv)(I)(II). The Court finds clear statutory intent that eligibility refers to whether a patient is capable of receiving federal medical assistance or Medicaid. The phrase "the number of the hospital's patient days for such period" modifies the term eligible. The regulation interprets this to mean the days for which the State has paid. Eligibility refers to the qualification for benefits, not their actual receipt. Congress utilized the term "entitlement" in the Medicare proxy, and not in the Medicaid proxy. 42 U.S.C. §1395ww(d)(5)(F). The terms have clearly different meanings and are not designed to be commingled.

Legislative history tells us that all inpatient days for Medicaid-eligible patients regardless of state payment were to be given a cost adjustment. The House Committee in discussing the need for cost adjustments to hospitals serving a large number of low income patients stated that:

[i]f a patient is eligible for Medicaid at any point during his inpatient stay, all days of care attributable to that patient would be counted under the provision, whether or not actually

paid for by the Medicaid program.  
(Emphasis supplied).

House Report 241(L) at 17. See Plaintiffs' Motion for Summary Judgment, Attachment E1. Further, the legislative history of Senate Bill 1606 does not limit the number of days to those actually paid by state programs. Id. at Attachment F. Congress directed defendant to adopt a regulation carrying into effect Congress' will. Legal Environmental Assistance Foundation, Inc. v. U.S. E.P.A., 118 F.3d 1467, 1473 (11th Cir. 1997). The regulation adopted by defendant does not express Congressional intent, and thus is a nullity. Id. (citing Dixon v. United States, 381 U.S. 68, 74 (1965)). Congress has directly spoken to the issue and defendant's interpretation is void *ab initio*. See Cabell Huntington Hospital, Inc., 101 F.3d at 990 (holding language of statute clear); Legacy Emanuel, 97 F.3d at 1266 (holding language of statute clear); Deaconess Health Servs., 912 F.Supp. at 447 (holding language of statute clear ). Plaintiffs are entitled to judgment as a matter of law.

### CONCLUSION

Defendant's Motion for Entry of Judgment is DENIED. Plaintiffs' Motion for Summary Judgment is

GRANTED. Defendant is directed to calculate plaintiffs' adjusted payments in accordance with plaintiffs' request subject to proper documentation. The Court retains jurisdiction of this matter to ensure proper payment.

The Court also declares 42 C.F.R. §412.106(b)(4) is void *ab initio*. The Court orders defendant to report every 3 months in writing to this Court regarding rescission of it and the status of any successor regulation.

IT IS SO ORDERED this 13th day of April, 1998.

/s/  
WAYNE E. ALLEY  
UNITED STATES DISTRICT  
JUDGE

ENTERED ON JUDGMENT DOCKET ON APR 13 1998

APPENDIX D

**ANADARKO MUNICIPAL HOSPITAL v.  
SHALALA, CIV-97-288-A**

**SECRETARY'S FIRST QUARTERLY REPORT  
DATED JUNE 10, 1998**

IN THE UNITED STATES DISTRICT COURT FOR THE  
WESTERN DISTRICT OF OKLAHOMA  
OKLAHOMA CITY DIVISION

ANADARKO MUNICIPAL )  
HOSPITAL, et al., )

Plaintiffs, )

v. )

DONNA E. SHALALA, )  
SECRETARY, )  
DEPARTMENT OF )  
HEALTH AND HUMAN )  
SERVICES, )

Defendant. )

Case No. CIV-97-0288-A

DEFENDANT'S REPORT TO THE COURT

Pursuant to this Court's April 13, 1998 Order, which directed Defendant to report every three months in writing to this Court regarding rescission of 42 C.F.R. § 412.106(b) (4) and the status of any successor regulation, the Defendant reports the following:

1. On May 8, 1998, the Defendant-Secretary issued a Notice of Proposed Rulemaking (NPRM) entitled, "Medicare Program: Changes to the Hospital Inpatient

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Prospective Payment Systems and Fiscal Year 1999 Rates.”  
63 Fed. Reg. 25576 (1998).

2. This NPRM would amend 42 C.F.R. § 412.106(b) (4) by replacing the Secretary's original interpretation of the Medicaid fraction for the disproportionate patient percentage in section 1886(d) (5) (F) (vi) (II) of the Social Security Act, 42 U.S.C. § 1395ww(d) (5) (F) (vi) (II), with the interpretation declared by this and other courts. 63 Fed. Reg. at 25594-95, 25606. Specifically, the NPRM would revise § 412.106(b) (4) to include each hospital patient day for a patient eligible for Medicaid on such day, regardless of whether particular items or services were covered or paid under an approved State Medicaid Plan. 63 Fed. Reg. At 25595, 25606.

3. The proposed revision to § 412.106(b) (4) would apply to cost reporting periods beginning on or after October 1, 1998. 63 Fed. Reg. At 25595.

4. The May 8, 1998 NPRM addresses the annual update of matters pertaining to the prospective payment system for acute care hospitals participating in the Medicare program. See 42 U.S.C.A. § 1395ww(E) (5) (a). The NPRM

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is scheduled to be finalized by August 1, 1998. See 42.  
U.S.C.A. § 1395ww(e) (5) (B).

Respectfully submitted,

PATRICK M. RYAN  
United States Attorney

/s/

KAY SEWELL  
Assistant United States Attorney  
210 West Park Avenue  
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Oklahoma City, OK 73102  
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## LETTER TO HCFA REGARDING CLARIFICATION OF RULING 97-2

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July 21, 1997

OF COUNSEL

David A. Bennett

**Via Facsimile and First Class Mail**

Ms. Anne Rudolph

Health Care Financing A

Health Care Financing Administration

MS-/C5-06-27

7500 Security Blvd.

Baltimore, MD 21244

Re: Medicare Disproportionate Share

HCFA Ruling 97-2

Reopenings To Include Additional Covered Medicaid  
Days

Dear Ms. Rudolph:

Thank you for your voice mail message of last week regarding my inquiry as to the meaning of HCFA Ruling 97-2 and the follow-up memorandum dated June 12, 1997. As I explained in my voice mail left for you, my inquiry concerns comments made to me by Mark Smith of Blue Cross of Oklahoma regarding reopenings, a subject that is not covered in the Medicare disproportionate share (DSH) litigation currently under way in Oklahoma. As requested in your voice mail to me, I set forth below the context and my specific question.

As you may know, we have been working with the State of Oklahoma to obtain data regarding paid and denied claims submitted by Oklahoma hospitals to the Oklahoma Medicaid program. While the process of obtaining and analyzing this data has been ongoing, we have filed reopening requests with Blue Cross of Oklahoma. The intent of our reopenings is to add, based on State-supplied documentation, additional paid and covered Medicaid days, that is, days that HCFA agreed to incorporate into the Medicare DSH calculation under the Secretary's interpretation of the DSH statute prior to HCFA Ruling 97-2. Recently, Mr. Smith called and informed me that he would be denying all reopening requests pursuant to HCFA Ruling 97-2. I explained to him that we intended to supply documentation of additional covered days, and that I did not understand HCA Ruling 97-2 or the June 12<sup>th</sup> memo as precluding a reopening to include

such days. He cited to me his conversation with you and the numbered paragraph 4 in the June 12<sup>th</sup> memo, which states as follows:

4. If a cost report was settled prior to February 27, 1997, and the hospital has not filed a jurisdictionally proper appeal on this issue (Medicaid days), its cost report should not be reopened to recalculate Medicaid days, whether or not the three year period for discretionary reopening has expired. This is true even if the cost report is subsequently reopened for other issues, including other Medicare disproportionate share issues which do not affect Medicaid days. This would include reopenings to recalculate Medicare Part A/SSI days.

Our specific question is this: Does the above quoted paragraph, other portions of the June 12<sup>th</sup> memo, and/or HCFA Ruling 97-2, preclude a reopening to add Medicaid days to the DSH calculation if HCFA would have included such days under the Secretary's interpretation of the statute prior to the issuance of

HCFA Ruling 97-2? For example, if we can document from State of Oklahoma records that a hospital had paid Medicaid days in excess of the amount used by the fiscal intermediary to finalize the cost report, can a hospital reopen its cost report within the three-year reopening time period, to add the additional paid days?

We would appreciate greatly hearing from you regarding this inquiry as soon as possible. If HCFA is taking the position that no reopenings will be allowed even to include paid Medicaid days, we would appreciate an explanation of HCFA's position. We make this request because our understanding of the Secretary's position on reopenings is that they will be allowed only to the extent that new and material evidence is provided and only in accordance with the law at the time the cost report was finalized. Because the Secretary's Medicaid paid day interpretation of the DSH statute was used to finalize the cost reports in question, it seems appropriate for reopenings to be allowed to include additional days that would be included under that interpretation.

Should you have any questions regarding this inquiry, please contact me at 206-622-5511.

Very truly yours,

BENNETT & BIGELOW, P.S.

/s/

Sanford E. Pitler

SEP:wss

cc: Mr. Mark Smith  
Blue Cross of Oklahoma

Thomas L. Weinberg, Esq.  
Elizabeth A. McFall, Esq.  
Mr. Daniel A. Evans  
Bennett & Bigelow, P.S.

JUL 29 1998

OFFICE OF THE CLERK

# In the Supreme Court

OF THE

## United States

OCTOBER TERM, 1997

YOUR HOME VISITING NURSE SERVICES, INC.,  
*Petitioner,*

v.

DONNA E. SHALALA,  
Secretary of Health and Human Services,  
*Respondent.*

### BRIEF OF AMICI CURIAE

**The American Hospital Association and  
The Federation of American Health Systems  
in Support of Petitioner**

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**QUESTIONS PRESENTED**

1. Whether there is jurisdiction for review of refusals by fiscal intermediaries to reopen Medicare providers' cost reports under 42 U.S.C. § 1395oo, 28 U.S.C. § 1331, 28 U.S.C. § 1361 and/or 5 U.S.C. § 706?

2. Whether 42 C.F.R. § 405.1885(c) is based on a permissible construction of the Medicare statute?

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## INTEREST OF *AMICI CURIAE*

With the written consents of both parties, which have been filed with the Court, *amici curiae* respectfully submit this brief in support of petitioner, Your Home Visiting Nurse Services, Inc.<sup>1</sup>

*Amici curiae* are two associations of health care providers. The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. The AHA's mission is to promote high quality health care and health services through leadership and assistance to hospitals in meeting the health care needs of their communities. Its membership includes approximately 5,000 hospitals, health systems, networks and other providers of care. In addition, over 40,000 health care professionals hold individual memberships in the AHA.

The Federation of American Health Systems is the national trade organization representing approximately 1,700 privately owned and managed community hospitals and health care systems. These systems provide comprehensive health care services across the acute and post-acute spectrum. The majority of the freestanding specialty hospitals in the United States are represented by the Federation.

The overwhelming majority of *amici's* members participate as providers of services in the Medicare program. 42 U.S.C. §§ 1395-1395eee. Medicare payments for services rendered to beneficiaries account for approximately forty percent of the revenue of the average member hospital. Hospitals and other health care providers rely on Medicare as a major source of revenue to assure their financial survival. Any substantial loss of Medicare payments can

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<sup>1</sup> Counsel for *amici curiae* listed on the cover authored this brief in whole. No party, other than *amici curiae*, its members or its counsel has made a monetary contribution to the preparation or submission of this brief.

affect a provider's continued ability to provide needed services to Medicare beneficiaries and others in the community. Accordingly, *amici* have an immediate and continuing interest in the integrity of the payment process and in the adequacy of the procedures in place to assure accurate payment determinations.

*Amici's* members, as participants in Part A of the Medicare program, must submit annual cost reports. The cost report is a complex document that addresses virtually every financial aspect of the operations of a provider. Beginning with the provider's financial books and records, the cost report involves thousands of calculations and the application of volumes of statutes, regulations and policies to the financial activities of the provider over the fiscal year to determine a total annual reimbursement amount. A single cost report adjustment can increase or decrease a provider's Medicare reimbursement by millions of dollars.

To assure the accuracy of the annual payment determination, the Secretary of Health and Human Services ("Secretary") has promulgated a regulation which allows for the reopening of cost reports within three years. 42 C.F.R. § 405.1885. The Secretary, as well as providers, routinely avail themselves of the reopening process to address new, material evidence and to correct clear and obvious errors of fact and law in the payment determination. The Secretary asserts here that the decision of a Medicare fiscal intermediary to deny a provider's request to reopen its cost report may not be reviewed by any individual, agency, administrative tribunal or court. Given the importance of the cost reporting process in the determination of Medicare reimbursement, this delegation of absolute and final discretion to an employee of a private contractor cannot be sustained.

If the Court upholds the Sixth Circuit's decision in *Your Home Visiting Nurse Services, Inc. v. Secretary of Health and Human Services*, *amici's* members will continue to be

subject to arbitrary decisions by employees of private government contractors on reopening issues that may have substantial financial consequences.

## SUMMARY OF ARGUMENT

This case represents another in a long line of attempts by the Secretary to deny providers administrative and judicial review of her Medicare payment determinations. The Secretary interprets the Medicare statute and regulations to preclude any review whatsoever of the determination of a fiscal intermediary to deny a provider's request for reopening of its cost report. Because the jurisdictional statute in question, 42 U.S.C. § 1395oo, clearly and unequivocally authorizes the Provider Reimbursement Review Board ("Board") to review any final intermediary determination that affects a provider's total annual reimbursement, the Secretary's restrictive reading must be rejected.

In addition, the Secretary's reopening process is ripe for abuse, and is fundamentally unfair to Medicare providers. She has delegated blanket discretion to deny reopening requests to private intermediaries that are known to have business interests in conflict with the interests of providers. Through the performance standards imposed on intermediaries, she has created additional incentives against the reopening and correction of erroneous determinations. The potential abuses inherent in the Secretary's reopening scheme do not stop at the intermediary level. The Secretary has demonstrated her willingness to take advantage of the process. She directs intermediaries to reopen cost reports to recoup overpayments, and, at times, directs them *not* to reopen when the correction of errors would result in additional payments to providers. Although the potential for abuse could be mitigated through administrative and judicial review, the Secretary has chosen to deny the very protection Section 1395oo was intended to provide.

*Amici* urge the Court to reverse the Sixth Circuit's decision in *Your Home*, and to hold that, pursuant to the statutory directive of Section 1395oo, the Board has jurisdiction to review denials of reopening. Alternatively, if the Court finds that the Medicare statute does not confer jurisdiction, the other grants of jurisdiction urged by petitioner should apply to protect providers from the arbitrary denial of payments due under the Medicare statute.

## ARGUMENT

### I.

#### MEDICARE PROVIDERS ARE ENTITLED TO ADMINISTRATIVE REVIEW OF REFUSALS TO RE-OPEN COST REPORTS UNDER THE MEDICARE STATUTE

##### A. The Secretary's Inequitable Implementation Of The Administrative Review Process.

Congress has established the Provider Reimbursement Review Board as the administrative forum for review of Medicare Part A payment determinations. The governing statute sets forth three conditions that a provider must meet to trigger the Board's jurisdiction. A hearing is available if the provider:

(1)(A)(i) is dissatisfied with a final determination of... its fiscal intermediary... as to the amount of total program reimbursement due the provider... for the period covered by such report...

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(2) the amount in controversy is \$10,000 or more, and

(3) such provider files a request for a hearing within 180 days....

42 U.S.C. § 1395oo(a) (Supp. 1998). *See also* 42 C.F.R. § 405.1835 (1997).

The Board's jurisdiction will typically be invoked after a provider has filed a cost report with its fiscal intermediary, and the intermediary has reviewed the cost report and has issued a payment determination known as a "Notice of Program Reimbursement." *See* 42 C.F.R. § 405.1803. Under the regulations, a provider may file an appeal with the Board within 180 days after the issuance of the Notice of Program Reimbursement, after the issuance of a revised notice, or within 180 days after certain other determinations. 42 C.F.R. §§ 405.1841(a), 405.1889, 413.30(c), 413.40(e). It is the Secretary's view, however, that an appeal is not available after a request to reopen a prior determination has been denied.

The reopening rule at issue in this case provides that an intermediary's determination may be reopened, so long as a request is made within a three year period. 42 C.F.R. § 405.1885(a). The Provider Reimbursement Manual limits reopening to cases where (1) new and material evidence has been submitted; (2) a clear and obvious error has been made; or (3) a determination is found to be inconsistent with the law, regulations and rulings, or general instructions. Provider Reimbursement Manual (HIM-15) § 2931.2, *reprinted in* 2 Medicare & Medicaid Guide (CCH) ¶ 7739 [hereinafter Manual].<sup>2</sup> Although it makes an exception for providers located in the Ninth Circuit, the Manual states that a refusal by the intermediary to grant a reopening request is not appealable to the Board and cites 42 C.F.R.

<sup>2</sup> Although it does not have the force and effect of law, the Manual provides guidance regarding the Secretary's interpretation of the law.

§ 405.1885(c) as the authority for this restriction.<sup>3</sup> Manual, *supra* at Appendix A to § 2926, ¶ B.4, reprinted in 2 Medicare & Medicaid Guide (CCH) ¶ 7719G. This attempt to limit review of the intermediary's determination must be rejected.

**B. The Plain Language And Clear Intent Of Section 1395oo Provide For Review Of Reopening Determinations.**

In determining whether the Board has jurisdiction to review an intermediary's denial of reopening, the plain meaning of the statute must control. *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 403 (1988). See also *Bailey v. United States*, 516 U.S. 137, 144-45 (1995) (In interpreting the meaning of a statute, courts must start with the language of the statute.). A decision by the intermediary not to reopen a provider's cost report is unquestionably a "final determination of the . . . fiscal intermediary . . . as to the amount of total program reimbursement due the provider." 42 U.S.C. § 1395oo(a)(1)(A)(i). It is a decision that the provider is not entitled to the reimbursement it seeks, despite the new and material evidence, or the clear error of fact or law, presented by the provider.

The Secretary has conceded in the past, and the Sixth Circuit has agreed, that the decision not to reopen is a final determination, at least in some sense. *Oregon v. Bowen*, 854 F.2d 346, 349 (9th Cir. 1988); *Your Home Visiting Nurse Servs., Inc. v. Secretary of Health and Human Servs.*, 132 F.3d 1135, 1138-39 (6th Cir. 1997) (quoting *Good Samaritan Hosp. Reg'l Med. Ctr. v. Shalala*, 85 F.3d 1057, 1061 (2nd Cir. 1996)). However, the Sixth Circuit reached the erroneous conclusion that this final determination is not

<sup>3</sup>Section 405.1885(c) provides: "Jurisdiction for reopening a determination rests exclusively with that administrative body that rendered the last determination or decision."

related to the amount of program reimbursement due a provider. Where a provider makes a timely and proper request for reopening seeking additional reimbursement, the denial of that reopening is a final determination by the intermediary that the provider's total amount of program reimbursement will not include the additional amount requested. While a denial of reopening may be, as the Sixth Circuit would characterize it, a refusal by the intermediary to revisit the first determination, this does not alter the fact that the intermediary, in denying reopening, has made another determination as to the total amount of the provider's Medicare reimbursement. Indeed, the Ninth Circuit has explicitly recognized that denials of reopening "directly implicate" a provider's amount of total program reimbursement. *Oregon v. Bowen*, 854 F.2d at 349.

In *Bethesda Hospital Association*, the Court was faced with a similarly narrow interpretation of the Board's jurisdiction under Section 1395oo. 485 U.S. 399. In that case, the Secretary attempted to preclude the Board from reviewing a provider's challenge to the validity of a regulation, because the provider failed to obtain the intermediary's determination on the specific cost item at issue. She argued that, because a provider must be "dissatisfied" with a final determination of the intermediary, a provider is entitled only to a hearing on claims actually presented first to the intermediary. The Court properly refused to entertain the Secretary's "strained interpretation," and found that the express language of that section requires nothing more than a provider's dissatisfaction with a final determination of its program reimbursement. *Id.* at 404. Here, the Court should confirm the broad grant of authority to the Board under Section 1395oo and should similarly refuse to narrow the Board's jurisdiction under an equally strained interpretation of the term "final determination."

Although the plain meaning of the statute decides the issue presented here, additional support for a broad reading of Section 1395oo is found in its legislative history.<sup>4</sup> The Court must give effect to the unambiguously expressed intent of Congress. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 n.9 (1984). See also *Regions Hosp. v. Shalala*, 118 S. Ct. 909, 915 (1998).

The legislative history of Section 1395oo demonstrates that Congress intended to give providers a definite administrative means by which to appeal an intermediary's final determination. Social Security Amendments of 1972, H.R. Rep. No. 92-231 (1972), reprinted in 1972 U.S.C.C.A.N. 4989, 5094. Specifically, when Congress identified the lack of any provision for an appeal by a provider of an intermediary's determination, it established the Board to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items. *Id.*; *Tallahassee Mem'l Reg'l Med. Ctr. v. Bowen*, 815 F.2d 1435, 1459 (11th Cir. 1987), cert. denied, 485 U.S. 1020 (1988). The Sixth Circuit's conclusion that the Board did not have jurisdiction over the intermediary's determination on reopening is directly inconsistent with this legislative history.

Moreover, nothing in the legislative history suggests that Congress intended to prohibit all judicial review of denials of reopening. Neither the Sixth Circuit, nor the other circuit courts that have examined this issue, have identified any legislative history to support the preclusion of Board review

<sup>4</sup>In *Bethesda Hosp. Ass'n*, for example, after the Court examined the express language of Section 1395oo(a) and concluded that the plain language was determinative of the issue, it continued its analysis by examining the "language and design of the statute as a whole." 485 U.S. at 405 (citations omitted).

of denials of reopening.<sup>5</sup> *Good Samaritan Hosp. Reg'l Med. Ctr.*, 85 F.3d 1057 (2nd Cir. 1996); *Athens Community Hosp., Inc. v. Schweiker*, 743 F.2d 1 (D.C. Cir. 1984); *Saint Mary of Nazareth Hosp. Ctr. v. Schweiker*, 741 F.2d 1447 (D.C. Cir. 1984). In the absence of such evidence, the strong presumption that Congress intends judicial review of administrative action must control. *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 676 (1986).

The Court should adopt the sound reasoning of the Ninth Circuit in the *Oregon v. Bowen* case which is in accord with the presumption of judicial review and which found support for Board jurisdiction in the plain meaning and congressional intent of Section 1395oo. If the Board and the courts are prevented from reviewing denials of reopenings, providers that are faced with new and material evidence or clear and obvious errors, will be without recourse, thereby nullifying the very purpose behind Section 1395oo. As the *Oregon v. Bowen* court found, the Secretary's position that the Board does not have jurisdiction over reopening denials would "partly eviscerate[ ] the congressional intent of providing administrative review of a fiscal intermediary's cost determination because [the Secretary's] policy would allow questions of mistaken cost determinations to go unreviewed." 854 F.2d at 350.<sup>6</sup> Finding that there was no reason

<sup>5</sup>In fact, when Congress intends that Board and judicial review of a particular matter should be precluded, it addresses the issue directly through the statute. *E.g.*, 42 U.S.C. § 1395oo(g), prohibiting review of determinations made pursuant to 42 U.S.C. §§ 1395y and 1395ww(d)(7); 42 U.S.C. § 1395yy(e)(8), precluding administrative and judicial review of certain portions of the prospective payment system rates under 42 U.S.C. §§ 1395ff or 1395oo.

<sup>6</sup>The Ninth Circuit found support for the review of reopening determinations in the Medicare statutory provision calling for "retroactive corrective adjustments" to assure that reimbursement is neither inadequate nor excessive. 42 U.S.C. § 1395x(v)(1)(A)(ii). The Ninth Circuit's decision is consistent with this Court's reading of the same

to conclude that Congress intended to prevent review, the court held that the Board had jurisdiction to review a denial of a reopening request. *Id.* at 349-50.

### C. Review Of Reopening Denials Is Not Inconsistent With The 180-Day Appeal Limit.

The Sixth Circuit decision in *Your Home* reflects a concern that administrative appeals of reopening denials would somehow frustrate Congress' intent that there be a 180-day time limit by which providers must appeal a final determination. 132 F.3d at 1139. However, permitting an appeal from a reopening denial in no way dissipates the 180-day appeal deadline. A provider would continue to be subject to the 180-day time limit which, pursuant to the statutory language, would run from the most recent determination, *i.e.*, the refusal to reopen.

In fact, the Secretary's regulations recognize that there may be more than one final determination with respect to an annual cost report and, as a result, more than one 180-day appeal period. Providers may request a hearing before the Board within 180 days of each revised determination issued after a reopening. 42 C.F.R. § 405.1889. Similarly, a provider may appeal a denial of an exception to, or exemption from, certain cost limitations. 42 C.F.R. §§ 413.30(c), 413.40(e)(4)-(5). Clearly, the Secretary has not read Sec-

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provision as a "year-end book balancing" requirement. *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 414 (1993). The reopening process allows for retroactive corrective adjustments within three years to assure that final payment is consistent with the Secretary's regulations, thereby assuring the accuracy of the year-end book balancing. The Ninth Circuit correctly concluded that nothing in Section 1395x(v)(1)(A)(ii) suggests nonreviewability.

tion 1395oo to authorize only a single 180-day appeal period.<sup>7</sup>

Moreover, the reopening process itself evidences the Secretary's conclusion that the need for accuracy in the reimbursement determination should override the finality concerns that would be served by imposing a single 180-day appeal limit. In *Regions Hospital*, the Court examined the Secretary's authority to reopen and reaudit cost reports beyond the three year reopening period for purposes of determining base year costs to be used under a new payment methodology. The Secretary took the position that the results of the reaudit would be applied to those cost reporting periods still within the three year reopening window. Neither the Court nor the Secretary was concerned that this approach would undermine the finality concerns underlying the 180-day appeal limit. Instead the Court considered the "three-year reopening window" as the applicable statute of limitations after which a cost report would be considered closed and final. 118 S. Ct. at 913, 915-16, 918.

Arguing that the three year time limit should not prevent the reaudit, the Secretary in the *Regions Hospital* case maintained that the reaudits were necessary "[t]o prevent perpetuation of past mistakes under the new . . . methodology," and to ensure that future payments would be based on an "accurate" determination. *Id.* at 914. The Court was persuaded to permit the reaudit based on the Secretary's

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<sup>7</sup>The regulations also permit the Board to extend the 180-day appeal limit for good cause. 42 C.F.R. § 405.1841(b). See also *Western Med. Enters., Inc. v. Heckler*, 783 F.2d 1376, 1379 (9th Cir. 1986), in which the court held that the 180-day time limit does not bar the Secretary from extending the time limit for good cause, because "1395oo is not a narrow jurisdictional statute." That court evaluated the language and history of 1395oo(a) and determined that Congress did not intend to create a "jurisdictional bar" to extension of the time limit by the Board. *Id.*

assertion that Congress, when it changed Medicare payment methodologies, "surely did not want to cement misclassified and nonallowable costs into future reimbursements, thus perpetuating literally million-dollar mistakes." *Id.* at 917. The Secretary's interest in accuracy overrode concerns of finality. It is hypocritical for the Secretary to now argue that providers are time barred from requesting review because the initial 180-day period has run from the intermediary's first determination, when that limit was of no concern to her under the reaudit rule.<sup>8</sup>

The Sixth Circuit also relied on the Court's decision in *Califano v. Sanders*, 430 U.S. 99 (1977), as support for the argument that permitting appeals of reopening denials would frustrate the congressional purpose to impose a 180-day limitation. *Your Home*, 132 F.3d at 1139. The Court in *Sanders* interpreted appeal provisions related to social security disability benefits. In that case, the Court held that judicial review was not available for a denial of a Social Security claimant's request for reopening, in part because it would frustrate the congressional purpose behind a 60-day time limit on requesting judicial review. *Sanders*, 430 U.S. at 108. The Sixth Circuit's reliance on this case, however, is misplaced. Unlike the three year time limit on requests for reopening, the regulation at issue in the *Sanders* case did not provide a time limit on requests for reopening, and indeed, the Social Security claimant had waited seven years to request reopening. Additionally, the claimant in *Sanders* merely sought a redetermination of his case and made no

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<sup>8</sup> Interestingly, when the provider in the *Regions Hospital* case complained that the Secretary's reaudit rules jeopardized finality, the Court consoled the provider by indicating that court review under the Administrative Procedure Act "should protect the Hospital from any future reaudits performed without legitimate reason." 118 S. Ct. at 916 n.2. The petitioner here should similarly be protected from the intermediary's refusals to reopen "without legitimate reason."

allegation of new evidence. Under the applicable Medicare reopening standards, reopenings are limited to cases where there is new and material evidence presented, a clear and obvious error, or a determination is found to be inconsistent with law or regulations. Manual, *supra*, § 2931.2. Finally, and most importantly, the claimant in *Sanders* was able to avail himself of "administrative channels" and have an Administrative Law Judge rule on his reopening request. 430 U.S. at 102-03. Unless the Court overrules the Sixth Circuit decision in this case, however, there is absolutely no review of the intermediary's determination — judicial, administrative or otherwise.

The more recent Supreme Court case of *Interstate Commerce Commission v. Brotherhood of Locomotive Engineers*, 482 U.S. 270 (1987), is more on point here. That case involved a challenge to the Interstate Commerce Commission's refusal to reconsider an order that it had issued. Based on the facts of the case and the failure of the party to allege new evidence or changed circumstances, the Court decided that the denial of the request was not subject to judicial review. However, the Court noted that the result would be different under other circumstances:

If review of denial to reopen for new evidence or changed circumstances is unavailable, the petitioner will have been deprived of all opportunity for judicial consideration — even on a "clearest abuse of discretion" basis — of facts which, through no fault of his own, the original proceeding did not contain.

*Id.* at 279. The Court's reasoning in *Locomotive Engineers* is directly applicable here. Under the Medicare rules, providers are entitled to reopening only where new and material evidence exists or where clear and obvious errors of fact or law are present. If the Board's review of a denial of reopening is foreclosed, Medicare providers will be denied the

opportunity for review, even in cases where the intermediary has committed the clearest abuse of discretion with respect to those facts. This result is inconsistent with the clear legislative history of Section 1395oo reflecting congressional intent to *favor* administrative and judicial review. Congress did not intend providers to be subjected to the whims of intermediaries without the opportunity for administrative and judicial review. As the district court for the Northern District of California noted:

The fiscal intermediaries are merely contractors. They are not officers of the Secretary. Under the Secretary's view, the fiscal intermediary could reject *all* requests to reopen, whether or not the requests had merit, and the Review Board could not intervene. This interpretation contradicts the broad authority Congress granted to the Review Board in 42 U.S.C. § 1395oo(d).

*Kootenai Hosp. Dist. v. Bowen*, 650 F. Supp. 1513, 1520 (N.D. Cal. 1987) (emphasis in original). The Sixth Circuit's holding that reopening denials are not subject to Board review, therefore, conflicts with the plain meaning and congressional intent of Section 1395oo, and should be reversed.

#### **D. The Secretary's Interpretation Violates Fundamental Principles Of Fairness And Administrative Law.**

Although the federal government frequently contracts with private parties for the performance of various functions, the Secretary's delegation of unfettered discretion to an employee of a private contractor appears to be unprecedented.<sup>9</sup> While it is true that the Court in *United States v.*

<sup>9</sup>Generally, where delegation by a federal agency to a private party has been upheld, the agency has retained final reviewing authority. See *R.H. Johnson & Co. v. Sec. & Exch. Comm'n*, 198 F.2d 690 (2nd Cir.

*Erika, Inc.*, 456 U.S. 201 (1982) upheld the delegation of final decision-making authority to Medicare carriers under Part B of the program, that case arose in a completely different context and is easily distinguishable. In *Erika*, the Court precluded judicial review only in the face of a clear congressional directive to limit review of payment determinations made by carriers (the Part B counterpart to Part A intermediaries) involving relatively small individual claims that arise under Part B. The Court was persuaded by extensive legislative history indicating that Congress sought to avoid overloading the courts with "quite minor matters." 456 U.S. at 209 (citing legislative history to the Social Security Amendments of 1972, 118 Cong.Rec. 33992 (1972)).<sup>10</sup>

No such congressional directive exists here. On the contrary, Congress has expressed an unequivocal intent to assure Medicare Part A providers adequate administrative and judicial review of their payment determinations. H.R. Rep. No. 92-231 (1972), *reprinted in* 1972 U.S.C.C.A.N.

1952) (Commission's delegation to the National Association of Securities Dealers ("NASD") was proper since the Commission reviewed NASD's disciplinary findings), *cert. denied*, 344 U.S. 855 (1952); *Pistachio Group of the Ass'n of Food Indus. v. United States*, 671 F. Supp. 31 (Ct. Int'l Trade 1987) (finding valid an agency's delegation of authority to the New York Federal Reserve Bank ("NY Fed.") because the agency retained authority to review the NY Fed.'s determination of the exchange rate), *aff'd* 685 F. Supp. 848 (Ct. Int'l Trade 1988); *United Black Fund, Inc. v. Hampton*, 352 F. Supp. 898 (D.D.C. 1972) (recognizing as proper the delegation of authority from the agency to the United Way since the agency retained final reviewing authority).

<sup>10</sup>It is important to note that Congress itself apparently found the lack of judicial review to be untenable and amended the statutory provision at issue in *Erika* in 1986 to provide for judicial review of the determination of the amount of payment due under Part B, where the amount in controversy exceeds \$1,000. 42 U.S.C. § 1395ff(b)(1)(C); Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341(a)(1), 100 Stat. 1874, 2037 (1986).

4989, 5094-95. Nor can the payment disputes that arise in the reopening context be considered "minor matters" that do not justify the consumption of administrative or judicial resources. As the recent case of *Ashland Regional Medical Center v. Shalala* reflects, the payment amounts in dispute under a reopening can be substantial. — F. Supp. — (E.D. Pa. 1998), reprinted in [1998-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 46,201 (E.D. Pa. 1998). In that case, the reopening denial deprived the provider of more than five million dollars in Medicare reimbursement to which it was clearly entitled. Such substantial Medicare revenue can often mean the difference between the financial survival of a health care provider or the loss of an important health care service to the community.

*Your Home* also differs substantially from *Erika* in that a carrier hearing was available to the plaintiff in *Erika*, while the petitioner here has been denied any review process whatsoever. The petitioner in *Your Home* is faced with a summary denial issued by an intermediary employee, which merely states that the petitioner did not meet the requirements for reopening. No rationale was provided for rejecting the petitioner's allegations of new and material evidence and factual and legal errors. (Appendix to Petitioner's Petition for Certiorari at 9.) While the petitioner in *Erika* was granted the opportunity through the carrier hearing process to explore the basis for the initial denial and present its arguments, petitioner here had no process in which it could identify even the most egregious kind of bias on the part of the intermediary's employee.

Finally, the decision-making authority delegated to the carrier in *Erika* allowed for considerably less discretion on the part of the private contractor. Although payment amount determinations under Medicare Part B are governed by voluminous and specific rules and regulations, the decision as to whether to reopen a cost report is governed by the

three broad standards set forth in the Manual, *supra*, at § 2931.2. As the scope of discretion is broadened, so also is the possibility of an abuse of discretion heightened.

The dangers inherent in the delegation of broad discretion to private parties are particularly apparent in this case. Because their compensation from Medicare represents a significant source of revenue for intermediaries, it is in their interest to retain their multimillion dollar government contracts. To do so, they must continue to meet performance standards established by the Secretary. 42 U.S.C. § 1395h; 42 C.F.R. §§ 421.120-421.124. *See, e.g., 59 Federal Register* 46258 (1994). This creates strong incentives to deny reopenings based on such inappropriate factors as the time and cost of processing the changes requested by the provider.<sup>11</sup>

Congress has recently recognized the potential for conflicts of interest among Medicare contractors and has acted to mitigate those conflicts in a newly established contracting program. In 1996, Congress enacted the Medicare Integrity Program, establishing a new category of Medicare contractors that will assume many of the functions currently performed by Medicare carriers and intermediaries. The Medicare Integrity contractors must comply with the strict conflict of interest standards generally applicable to federal acquisition and procurement. 42 U.S.C. § 1395ddd(c)(3).

Addressing this requirement in the preamble to the proposed Medicare Integrity Program regulations, the Secretary expressly acknowledged the ever increasing potential for

<sup>11</sup> These dangers are underscored by the \$144 million Blue Cross/Blue Shield of Illinois recently agreed to pay to resolve federal charges of falsifying records to cover up its poor performance as a Medicare contractor. In the Office of Inspector General's News Release dated July 16, 1998, the OIG stated that such misconduct was not unprecedented. *Medicare Carrier Agrees To Pay Record \$144 Million Settlement*, OIG News Release (July 16, 1998) <<http://www.hhs.gov/progorg/oig/bcbs/hcscse.html>>.

actual and apparent conflicts of interest among Medicare contractors:

In recent years, however, Medicare intermediaries and carriers, like most health insuring organizations, have expanded their business and product lines to become large integrated health care delivery systems . . . . This creates a conflict of interest when the contractor reviews claims . . . and performs other payment safeguard activities for its . . . provider's and supplier's competitors.

We have been criticized for the lack of effective mechanisms to mitigate these conflicts of interest. Even when we are assured that proper mechanisms are in place, the appearance of a conflict remains in the eyes of competitors.

63 *Federal Register* 13590, 13592 (1998). The safeguards against conflicts of interest in the Medicare Integrity Program that have been included in the statute and proposed in the regulations were not in place to protect petitioner in this case and will not be available to other providers subject to intermediaries' discretion in the reopening process. Intermediaries will be free to disadvantage their competitors by improperly denying them substantial sums of Medicare reimbursement with impunity.

Even if there is no specific bias, the intermediary's employee could flip a coin to determine whether a reopening would be granted and there would be no review process to identify or remedy the abuse of discretion. While the Secretary, at some point, considered the reopening determination important enough to issue criteria governing the decision, she apparently now is willing to risk the possibility that those criteria may be applied arbitrarily or ignored altogether.

Further, the Secretary's interpretation leads to inconsistency among intermediaries in the application of the stan-

dards. This is particularly troublesome for the many multistate health care entities that are *amici's* members. For example, a hospital in Michigan may be granted a reopening and receive payment for a substantial cost, while its sister hospital in Ohio may be denied reopening and payment for the same type of cost, under the same circumstances, by another intermediary, another employee of the same intermediary or even the same employee. Clearly there is no rational basis for this result.

At first glance it may be difficult to understand why the Secretary would choose to allow such potential abuses to go totally unchecked where Section 1395oo provides the obvious means to assure the integrity of the reopening process through the availability of administrative and judicial review. The reason for the Secretary's position becomes clear, however, upon an analysis of the budgetary consequences of her position. Under her view, when a provider has been overpaid she may reopen the cost report determination and recoup the overpayment. If the provider has been underpaid, however, she can either direct the intermediary not to reopen the cost report to pay the additional amount due, or may rely on the intermediary's arbitrary denial of reopening to avoid payment. While this approach may be financially beneficial to the government, it is clearly inconsistent with the Secretary's obligations under the Medicare statute and is patently unfair to providers that have served Medicare beneficiaries with the expectation of payment in accordance with the law.

A comparison of the graduate medical education ("GME") regulations at issue in *Regions Hospital*, with the Secretary's implementation of the disproportionate share hospital ("DSH") adjustment calculation in HCFA Ruling

No. 97-2 (1997),<sup>12</sup> clearly demonstrates the Secretary's willingness to selectively use her skewed process to the detriment of providers.<sup>13</sup>

At issue in *Regions Hospital* was the Secretary's "reaudit" rule, under which she reaudited GME costs incurred in a base year to assure that future GME payments would be accurate. The reaudit rule was designed, in part, to permit recoupment of prior excess reimbursements for years in which cost reports had not become final, *i.e.*, within the three year window. 54 *Federal Register* 40286, 40302 (1989); 118 S. Ct. at 914. As the Court noted, the revised costs determined on reaudit were applied to those cost reporting periods "still open" under Section 405.1885. 118 S. Ct. at 914; 42 C.F.R. § 413.86(e)(1)(iii). The Secretary's authority to make such adjustments in the interest of accuracy and within the three year window was not challenged by the petitioner and was not questioned by the Court.

The concern for accuracy did not prevail, however, under HCFA Ruling No. 97-2. After four courts of appeals struck down an aspect of her calculation of special payments to DSH providers under 42 C.F.R. § 412.106(b)(4), the Secretary issued a ruling acquiescing in the courts' interpretation of the regulation. Application of the courts' rulings would have required additional payments to providers. Notwithstanding the fact that prior determinations made under

<sup>12</sup>Reprinted in [1997-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 45,105 (1997). HCFA Ruling No. 97-2 can also be found at its Website, <<http://www.hcfa.gov/regs/hr97-2.htm>>. HCFA Ruling No. 97-2 has been attached hereto for the Court's reference.

<sup>13</sup>GME and DSH represent special Medicare payments for hospitals that are intended to reimburse them for the costs of operating teaching programs and the high cost of treating unusually large numbers of poor patients, respectively.

the invalid policy were clearly inconsistent with law, and that reopening was therefore required under the Secretary's own criteria, HCFA Ruling No. 97-2 directs intermediaries not to reopen cost reports to pay the additional amounts due. HCFA Ruling No. 97-2 at 2 (Attachment at a-4).

If the Secretary's position is upheld in this case, she will avoid administrative and judicial review when reopening requests are denied based on the directive of HCFA Ruling No. 97-2, even in those four circuits in which the courts of appeals have ruled her prior method of determining DSH payments to be inconsistent with law. Congress could not have intended to insulate such blatant inequities from judicial scrutiny.<sup>14</sup> "Bureaucratic ordering of this sort should not go unchecked by a reviewing court." *Beverly Hosp. v. Bowen*, 872 F.2d 483, 486 (D.C. Cir. 1989).

## II.

### IF JURISDICTION IS NOT AVAILABLE UNDER SECTION 139500, JURISDICTION LIES UNDER 28 U.S.C. § 1331, 28 U.S.C. § 1361 OR 5 U.S.C. § 706

If the Secretary's construction of Section 139500 is upheld, *amici* support petitioner's assertion that alternative bases for federal court jurisdiction are available to determine whether the intermediary abused its discretion in this case. As noted above, the Court has clearly and consistently recognized the strong presumption that Congress intends judicial review of administrative action. *Michigan Academy*, 476 U.S. at 670; *Abbott Laboratories v. Gardner*, 387 U.S.

<sup>14</sup>The Secretary in her brief before the Sixth Circuit asserts that she could do away with the reopening process altogether. (Respondent's Brief Before the Sixth Circuit at 24 n.9.) While *amici* question her authority to do so without articulating a rational basis for the change, it seems unlikely that she would eliminate a process that is so dramatically slanted in her favor.

136, 140 (1967). The Sixth Circuit in this case relied on the Court's holding in *Califano v. Sanders* to overcome the presumption, suggesting that because the reopening process was created by regulation, rather than by statute, the presumption does not apply. However, the Court's action in *Immigration and Naturalization Serv. v. Doherty* suggests to the contrary. 502 U.S. 314, 322 (1992). In that case, the Court reviewed a decision to deny reopening of deportation proceedings under the abuse of discretion standard even though the reopening process is derived from regulations. Indeed, in numerous cases the Court has indicated that a decision in response to a request to reopen an administrative determination is subject to review, regardless of whether the reopening process is established by statute or regulation. See *Locomotive Eng'rs*, 482 U.S. at 292 n.7 (Stevens, J., concurring), and cases cited therein.

A review of the Court's decisions addressing federal court jurisdiction over claims arising under the Medicare statute indicates that, while the Court will scrupulously hold claimants to the statutorily created avenues to judicial review, where the statute provides no review process, federal question jurisdiction will be available. Compare *Michigan Academy*, 476 U.S. 667 (1986) (Court found jurisdiction under Section 1331) with *Heckler v. Ringer*, 466 U.S. 602 (1984) and *Weinberger v. Salfi*, 422 U.S. 749 (1975) (claimants required to exhaust administrative remedies). Only where there is an unambiguous statement of congressional intent to preclude judicial review altogether, will access to the courts be denied. *Erika*, 456 U.S. 201.

Here there is no evidence of a congressional intent to preclude jurisdiction. Therefore, if the statutorily established avenue to the courts through the Board is foreclosed in this case, jurisdiction to address the serious federal question presented by petitioner must lie under Section 1331. Even if the Court concludes that Section 1395oo does not make

denials of reopenings reviewable, this conclusion alone is not sufficient to support an implication that such denials cannot be reviewed under other grants of jurisdiction. More specific evidence of congressional intent to preclude review would be required to support a jurisdictional bar. *Michigan Academy*, 476 U.S. at 674.

The Secretary argues that 42 U.S.C. § 405(h) prevents any resort to Section 1331 as a source of jurisdiction. In the absence of persuasive evidence of legislative intent to delegate the reopening determination to the unfettered discretion of an intermediary's employee however, the Court should decline to indulge the government's extreme position that Congress intended no review at all of the substantial issues raised by petitioner. *Michigan Academy*, 476 U.S. at 680.<sup>15</sup>

In concluding that jurisdiction is available to review a denial of reopening under both Section 1331 and Section 1361, the District Court of the District of Columbia aptly stated:

[T]he Secretary cannot relegate providers to a dead-end procedure under the Medicare statute, and then argue that the provider loses because the Medicare statute is the exclusive means of redress. When such bureaucratic red tape strangles a provider's right to judicial review, the Court may invoke its federal question jurisdiction and mandamus power.

*Memorial Hosp. v. Sullivan*, 779 F. Supp. 1410, 1412 (D.D.C. 1991).

<sup>15</sup> If the Court concludes that all judicial review is precluded in this case, it will ultimately be faced with the "serious constitutional question" that will arise if Section 405(h) denies a judicial forum for constitutional claims. *Michigan Academy*, 476 U.S. at 681 n.12.

In the event that the Court concludes, however, that review is not available under Section 1331, *amici* join the petitioner in urging the Court to find that the district court may exercise its mandamus power to assure that the Secretary complies with her statutory obligation. In the alternative, *amici* urge the Court to reconsider its decision in *Sanders* and to find the Administrative Procedure Act, 5 U.S.C., chapter 7, as an independent source of jurisdiction.

### III.

#### AS INTERPRETED BY THE SECRETARY, THE REOPENING REGULATION IS INCONSISTENT WITH THE MEDICARE STATUTE

The reopening regulation, set forth at 42 C.F.R. § 405.1885, permits intermediaries to reopen cost reports within a three year period. Section 405.1885(c) states that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." Although this section of the regulation vests discretion with the intermediary to decide whether to reopen, nothing in this provision discusses the review of that determination. *Oregon v. Bowen*, 854 F.2d at 349.

Section 405.1885(c) cannot be read implicitly to preclude review of reopening denials. Although the Sixth Circuit found the regulations "silent as to whether a decision not to reopen is subject to review," it deferred to the language in the Manual that states that a refusal by the intermediary to grant a reopening request is not appealable to the Board. *Your Home*, 132 F.3d at 1138; Manual, *supra*, at Appendix A to § 2926, ¶ B.4. However, to the extent the Secretary's interpretation is inconsistent with the statute, it is unlawful. See, e.g., *United States v. Larionoff*, 431 U.S. 864, 872-73 (1977). As discussed above, the plain meaning of the statute, as well as the legislative history, mandate that

the Board be able to review all final determinations of the intermediary as to a provider's total reimbursement. Accordingly, the Manual section precluding review is invalid, and the court's decision in *Your Home* must be reversed. Further, any construction of the regulation itself to prohibit Board review is also invalid because it directly contradicts Section 1395oo.

The Sixth Circuit was persuaded to uphold the Secretary's interpretation of Section 1395oo and the reopening regulation, due in part, to its deference to the Secretary. Deference to the Secretary's interpretation, however, is inappropriate in this case. Courts remain the final authority on issues of statutory construction, and deference must yield to the clear meaning of the statute as revealed by its language, purpose and history. *Chevron*, 467 U.S. at 843 n.9. See also, *Edgewater Hosp., Inc. v. Bowen*, 857 F.2d 1123, 1130 (7th Cir. 1989), *modified*, 866 F.2d 228 (7th Cir. 1989). The statute is clear that the Board has jurisdiction over any final determination of the intermediary regarding a provider's Medicare reimbursement. An interpretation that conflicts with the statute is not entitled to deference. See *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 143 (D.C. Cir. 1986), citing *Chevron*, 467 U.S. at 842 ("If the intent of Congress is clear, that is the end of the matter.").

Even if the Court concludes that Section 1395oo is ambiguous, however, no particular deference to the Secretary is warranted in this case. The traditional deference granted to agency interpretations is based on the Court's respect for the agency's special competence regarding matters within its area of expertise. Procedural issues, however, do not implicate that special competence and therefore are subject to less deference. See e.g., *Nealon v. California Stevedore & Ballast Co.*, 996 F.2d 966, 969 (9th Cir. 1993). Because this issue pertains to an interpretation of the Board's jurisdiction, rather than the complexities of the

Medicare program, this Court need not accord any particular deference to the Secretary's contention that the Board lacks jurisdiction over reopening denials. *Tallahassee Mem'l Reg'l Med. Ctr. v. Bowen*, 815 F.2d at 1458 (Because Section 1395oo is a jurisdictional statute — "a type of statute with which courts are quite familiar" — rather than one involving the Secretary's interpretation of a "technical and complex" area, the court accorded less deference in order to "carefully consider any agency action that potentially has the effect of barring access to the federal courts.") *Cf.*, *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (Deference warranted because Medicare regulation regarding anti-distribution principle concerned "a complex and highly technical regulatory program" in which the identification and classification of relevant criteria required significant expertise.) (quoting *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991)).

As interpreted by the Secretary in the Manual, *supra*, Section 405.1885(c) is inconsistent with the plain language of the statute. The Court should find that 42 C.F.R. § 405.1885(c) does not preclude the Board's jurisdiction over reopening denials.

### CONCLUSION

*Amici* urge the Court to adopt the reasoning of the Ninth Circuit in *Oregon v. Bowen*, rejecting the Secretary's interpretation of Section 1395oo as inconsistent with the statute and congressional intent. Alternatively, the Court should find jurisdiction in the federal district court to review the denial of petitioner's claim under general federal question

jurisdiction, the court's mandamus powers or under the Administrative Procedure Act.

Dated: July 29, 1998

Respectfully submitted,

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The American Hospital  
Association and the  
Federation of American  
Health Systems

**Ruling No. 97-2****Date: February 1997**

This Ruling states the policy of the Health Care Financing Administration concerning the determination to change its interpretation of section 1886(d)(5)(F)(vi)(II) of the Social Security Act (the Act) and 42 CFR 412.106(B)(4) to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits. Under the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days for service for patients who were eligible on that day for medical assistance under a State Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.

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**MEDICARE PROGRAM**

Hospital Insurance (Part A).

**INTERPRETATION OF MEDICAID DAYS INCLUDED IN THE MEDICARE DISPROPORTIONATE SHARE ADJUSTMENT CALCULATION**

**PURPOSE:** This Ruling announces the Health Care Financing Administration's (HCFA) determination to change its interpretation of section 1886(d)(5)(F)(vi)(II) of the Social Security Act (the Act) and 42 CFR 412.106(B)(4) to follow the holdings of the United States Courts of Appeals for the Fourth, Sixth, Eighth, and Ninth Circuits. Under the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan in

the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.

**CITATIONS:** Section 1886(d)(5)(F) of the Social Security Act and 42 CFR 412.106(b)(4).

**PERTINENT HISTORY:** The Medicare disproportionate share hospital (DSH) adjustment calculation, which is set forth in section 1886(d)(5)(F) of the Act, has been the subject of a substantial amount of litigation. The adjustment is calculated by determining a hospital's disproportionate patient percentage which is the sum of two fractions, the Medicare fraction and the Medicaid fraction. In the Medicare fraction, the number of patient days for patients who (for those days) were entitled to both Medicare Part A and Supplemental Security Income (SSI) under Title XVI of the Act is divided by the total number of patient days for patients entitled to Medicare Part A for that same period. The Medicaid fraction consists of the number of patient days for patients who for those days "were eligible for medical assistance under a State plan approved under Title XIX [Medicaid] but who were not entitled to benefits under Medicare Part A" (section 1886(d)(5)(F)(vi)(II) of the Act), divided by the total number of patient days for that same period. The Medicaid fraction is the subject of this ruling.

In implementing the calculation of the Medicaid fraction, HCFA interpreted the statutory language to include as Medicaid patient days only those days for which the hospital received Medicaid payment for inpatient hospital services. This interpretation has been considered by the courts of appeals in four judicial circuits. The initial issue in the litigation was whether HCFA should have counted days for patients who had been found to be Medicaid eligible, but who had exceeded Medicaid coverage limitations on inpatient hospital days of service (and, consequently, no Medicaid payment was made for those days). In later cases,

plaintiffs challenged HCFA's exclusion of any days of inpatient hospital services for patients who met Medicaid eligibility requirements, regardless of the reason for which no Medicaid payment was made. In each of the cases, the court declined to uphold HCFA's interpretation, reasoning that the statutory language "eligible for medical assistance" would include days on which the patient meets Medicaid eligibility criteria regardless of whether payment is made.

Although HCFA believes that its longstanding interpretation of the statutory language was a permissible reading of the statutory language, HCFA recognizes that, as a result of the adverse court rulings, this interpretation is contrary to the applicable law in four judicial circuits.

In order to ensure national uniformity in calculation of DSH adjustments, HCFA has determined that, on a prospective basis, HCFA will count in the Medicaid fraction the number of days of inpatient hospital services for patients eligible for Medicaid on that day, whether or not the hospital received payment for those inpatient hospital services. This would not include days for which no Medicaid payment was made because of the patient's spenddown liability, because an individual was not eligible for Medicaid at that point.

Pursuant to this Ruling, Medicare fiscal intermediaries will determine the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. Days for patients that cannot be verified by State

records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

We will not reopen settled cost reports based on this issue. For hospital cost reports that are settled by fiscal intermediaries on or after the effective date of this ruling, these days may be included. For hospital cost reports which have been settled prior to the effective date of this ruling, but for which the hospital has a jurisdictionally proper appeal pending on this issue pursuant to either 42 CFR 405.1811 or 42 CFR 405.1835, these days may be included for purposes of resolving the appeal.

**RULING:** For all cost reporting periods beginning on or after February 27, 1997, the Medicare disproportionate share adjustment will be determined by including in the calculation of the Medicaid fraction set forth in section 1886(d)(5)(F)(vi)(II) of the Act the additional days as set forth above.

#### IV. EFFECTIVE DATE

This Ruling is effective *February 27, 1997*.

Dated: 2/27/97

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**Bruce C. Vladeck,**  
**Administrator,**